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Assessment of State Options for Expanding Health Coverage

A Report to the **Health Insurance for Indiana Families Committee,**

Indiana Family and Social Services Administration

by

Health Management Associates

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Health Management Associates (HMA) was retained by the Indiana Family and Social Services Administration (FSSA), on behalf of the Health Insurance for Indiana Families Committee (HIIF Committee), to prepare a report that provides an assessment of state options for expanding health care coverage to reduce the number of uninsured.

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Introduction

Expanding health care coverage to all Americans remains an unrealized goal and is the source of considerable controversy among state and federal policymakers as to how to close the coverage gap. According to the Census Bureau, in 2002, an estimated 43.6 million Americans were without health insurance during the entire year. Except for a two-year period, the number of uninsured people has continued to rise over the last decade even though for most of the period the economy was healthy and a number of government programs to expand coverage were implemented. Efforts over the past decade to expand coverage, at the federal, state and local levels, have been incremental and have focused on a variety of approaches including:

- Expansions of public programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP);
- Efforts to promote private-sector coverage through passage of state legislation to reform insurance markets;
- Tax-based reforms that are intended to make coverage more affordable for individuals;
- Community-level programs that provide better local coverage and/or access, and
- Increasing support for safety net providers.

This report focuses on the variety of options most commonly used by states to expand health coverage. Also, a discussion of current community-based initiatives to expand coverage and access has been included.

Public Program Expansions

Public health insurance programs, such as Medicaid and the State Health Insurance Program (SCHIP), play a vital role in providing health care coverage to millions of Americans who otherwise would have no source of coverage. As states consider options for expanding health care coverage to more of their citizens, they frequently look to options that rely on Medicaid and/or SCHIP funding to leverage the substantial federal funding that these programs provide. In addition to optional populations that states may elect to cover under the terms of existing Medicaid and SCHIP statutes and regulations, states have also taken advantage of the opportunity to obtain Medicaid and SCHIP "waivers" that allow the states to implement coverage expansions under less restrictive terms and conditions.

Indiana Medicaid Overview

Medicaid is a health care program for low-income individuals that is jointly financed by the state and federal governments. In Indiana, the federal financial share of Indiana's Medicaid program (known as the "FMAP") is approximately 62 percent while the state share is about 38 percent. (In the last two quarters of federal fiscal year (FFY) 2003 and the first three quarters of FFY 2004, however, Indiana's FMAP was increased to 65 percent as a result of the federal Jobs and Growth Tax Relief Reconciliation Act of 2003 that provided temporary fiscal relief to states.) Each state administers its own Medicaid program within broad federal guidelines. Thus, state programs vary in eligibility criteria, services covered, limitations on services and reimbursement levels. In all states, however, Medicaid plays a key role in the financing of state and local health care and is a key source of funding for hospitals, nursing homes, pharmacies, physicians and virtually every component of the health care system.

Medicaid Eligibility

State Medicaid programs are required by federal law to provide health care coverage to certain low-income individuals while others are covered at the states' option. To be eligible, a person must belong to one of the covered categories and meet specific eligibility criteria. The Indiana Medicaid Eligibility Overview Table attached as Appendix A lists the specific Indiana criteria for each eligibility category. With the exception of coverage for children (which has been significantly expanded in recent years due to the implementation of SCHIP), it is fair to say that Indiana's Medicaid eligibility standards are restrictive relative to other states. For example:

- While 18 states (as of November 2001)[1] had expanded coverage for low-income adults (with children) to income levels *above* 100 percent of the Federal Poverty Level ("FPL"), in Indiana, low-income adults (with children) wishing to qualify for Medicaid in 2003 may not have incomes exceeding 23 percent of the FPL;
- Indiana is one of only eleven states (known as "Section 209(b) states") with financial criteria for aged, blind and disabled enrollees that are more restrictive than the financial standards of the federal Supplemental Security Income ("SSI") program, and
- Indiana is one of only two states that applies a more restrictive medical definition of "disability" than the SSI program for purposes of qualifying for disability Medicaid.

In addition to exercising the option to cover children at income levels higher than the federal minimum,[2] Indiana also has elected to provide Medicaid coverage to the following optional groups:

- Pregnant women with incomes between 133 percent and 150 percent of the FPL;
- Uninsured women under age 65 who have been screened for breast or cervical cancer under a Centers for Disease Control funded program and need treatment (148 women in FY 2002). There are no income or asset limits;[3]
- Employed individuals with a disability up to 350 percent FPL enrolled in the "MEDWorks" program (with those over 150 percent FPL paying premiums on a sliding fee scale based on income);[4]
- Children medically eligible for a Medicaid home and community-based waiver ("HCBS waiver") program whose family income otherwise exceeds Medicaid limits;[5] and
- Persons enrolled in the Developmental Disabilities HCBS waiver or the Support Services HCBS waiver (also for persons with developmental disabilities) with incomes up to 300 percent FPL.

While the majority of Medicaid members are children (60 percent in FY 2002), the majority of expenditures are for the aged, blind and disabled (67 percent in FY 2002).

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[1] The 18 states included Arizona, California, Connecticut, District of Columbia, Delaware, Hawaii, Maine, Massachusetts, Minnesota, Missouri, New Jersey, New York, Ohio, Oregon, Rhode Island, Vermont, Washington and Wisconsin. Source: Broaddus, M., et al., *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000,* Center on Budget and Policy Priorities, February 13, 2002. Accessed on www.cbpp.org. In this study, only four states (Alabama, Arkansas, Louisiana and West Virginia) reported the same or lower income standard for low-income adults (with children) than Indiana.

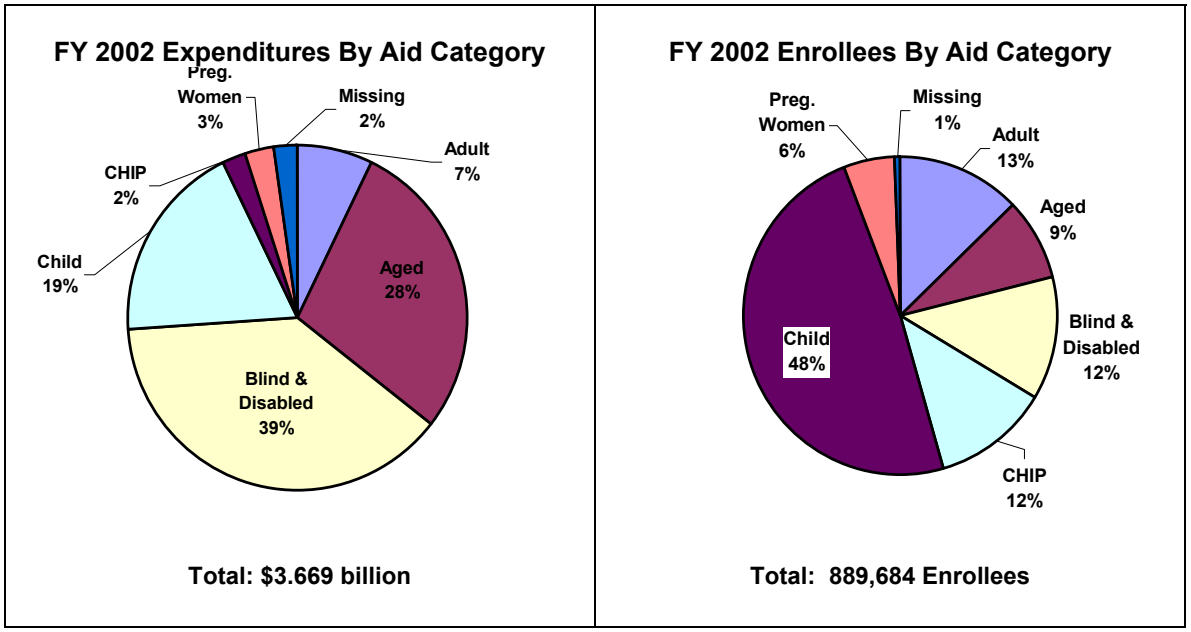
[2] Prior to the implementation of SCHIP, Indiana exceeded the federal minimum Medicaid child coverage standards only for newborns up to age one covering them up to 150 percent of the FPL rather than the federal minimum of 133 percent.

[3] This optional category was created by the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000" (P.L. 106-354).

[4] This optional category was created by the federal "Ticket to Work and Work Incentives Improvement Act of 1999" (P.L. 106-170).

[5] Under Indiana's Medicaid HCBS waivers, the parent's income is not counted.

Figure 1: FY 2002 Medicaid and SCHIP Expenditures and Enrollees by Aid Category



Medicaid Services

Coverage of certain basic services is required to qualify for federal matching funds. Also, states may elect to cover a variety of optional services approved by the federal government. Indiana provides 31 of 34 possible optional services making the Indiana Medicaid program one of the most comprehensive in the country.

Mandatory Services

- Early/periodic screening, diagnosis & treatment (EPSDT) under age 21
- Family planning services & supplies
- Inpatient hospital
- Lab & x-ray
- Nurse midwife
- Nurse practitioner
- Nursing facility/home health for age 21+
- Outpatient hospital
- Physician
- Rural health clinic & federally qualified health center

Optional Services Not Provided

- Personal Care
- Psychiatric nursing facilities (age 65+)
- TB-related

Optional Services

- Case Management
- Chiropractor
- Christian Science nurses
- Christian Science sanitariums
- Clinic
- Dental
- Dentures
- Diagnostic services
- Emergency hospital
- Eyeglasses
- Hospice care
- Inpatient hospital for age 65+ in institutions for mental disease
- Inpatient psychiatric (under age 21)
- ICF/MR
- Medical social worker
- Nurse anesthetist
- Nursing facility (under age 21)
- Occupational therapy
- Optometrist
- Physical therapy
- Podiatrist
- Prescribed drugs
- Preventive services
- Private duty nursing
- Prosthetic devices
- Psychologist
- Rehabilitative
- Respiratory therapy
- Screening services
- Speech/hearing/language disorders
- Transportation

Indiana SCHIP Overview

The State Children's Health Insurance Program (SCHIP) was authorized in 1997. Indiana implemented SCHIP in two phases. The first phase was a Medicaid eligibility expansion for children up to 150 percent of the FPL that began July 1, 1998. The second phase was a non-Medicaid program with premium and cost-sharing requirements and slightly different benefits covering children between 150 percent and 200 percent of the FPL. The second phase was implemented January 1, 2000.

All states receive annual federal SCHIP allotments that may be spent over three years. At the end of the three-year period, unspent allotments must be returned.[6] Reverted funds are then redistributed to the states that have fully expended their annual allotments. Indiana's current annual federal SCHIP expenditures (estimated at approximately $66.7 million in federal fiscal year 2004) exceed Indiana's current annual SCHIP federal allotment ($54 million in FFY 2004). However, because Indiana has previously received SCHIP redistributions, Indiana has substantial federal carry-over SCHIP funds and expects to continue to carry over federal SCHIP allotments for the next few years – even in the absence of additional future redistributions. Table 1 presents a summary of Indiana's current and expected utilization of SCHIP allotments and redistributions.[7]

Table 1: Indiana CHIP Federal Funding

Order of Expenditures	Amount	Status
1998 Allotment	$70.0 M	Spent all
1999 Allotment	$70.0 M	Spent all
1998 *redistribution*	$45.0 M	Spent all
1999 *redistribution*	$105.0 M	Entire redistribution reverted 10/1/02 but was reinstated through 10/1/04 – State expects to spend all
2000 Allotment	$63.0 M	$13M reverted 10/1/02 but $6.5M was reinstated through 10/1/04 – State expects to spend all
2001 Allotment	$60.0 M	State reverted $30.5M on 10/1/03 and expects to revert an additional $15M on 10/1/04
2002 Allotment	$47.0 M	State expects to revert the entire allotment on 10/1/04
2003 Allotment	$53.7 M	State expects to spend all (in FFY 2005)
2004 Allotment	$54.0 M	State expects to spend all (in FFYs 2005 and 2006)
2005 Allotment *	$61.0 M	State expects to spend all (in FFYs 2006 and 2007)
2006 Allotment *	$61.0 M	State expects to spend all (in FFY 2007)
2007 Allotment *	$61.0 M	State expects to spend all (in FFYs 2007 and 2008)

* Actual allotment amounts not yet determined/available.

[6] In August 2003, Congress extended the availability of SCHIP allotments and redistributions for FFYs 1998 and 1999 through September 30, 2004 and extended 50 percent of unexpended FFY 2000 allotments through September 30, 2004. P.L. 108-74.

[7] Based on information provided by Elizabeth Culp, Indiana CHIP Director, October 21, 2003.

Medicaid/SCHIP Expansions Using Section 1115 Waivers

Over the past decade, many states have proposed and implemented Medicaid coverage expansions utilizing "Medicaid waivers" authorized in the federal Social Security Act. Section 1115(a) of the Social Security Act allows the DHHS Secretary discretion to waive compliance with certain requirements of federal Medicaid law to enable a state to carry out an experimental, pilot or demonstration project which the DHHS Secretary determines is likely to promote the objectives of the federal Medicaid law.[8] In the 1970s and 1980s, the use of this statutory authority was limited as the federal government adhered closely to the "experimental" or "demonstration" requirement and required states not to replicate a concept already contained in another state's proposal. Arizona, which received a Section 1115 waiver when it became the last state to adopt a Medicaid program in 1982, was the first state (and the only state until 1994) to receive approval for a statewide "1115" Medicaid demonstration waiver.[9] During the 1990s, however, the Clinton Administration agreed to exercise greater flexibility in the approval of 1115 waiver requests leading to the approval of 17 comprehensive Medicaid demonstration approvals between 1994 and 1999 (including "TennCare" and the Oregon Health Plan's "Prioritized List of Condition/Treatment Pairs" in 1994). Thus, during the 1990's, Section 1115 waivers became the primary vehicle for statewide health care reform, in the absence of national health reform.[10]

The Bush Administration has continued the philosophy of providing states greater flexibility by announcing the Health Insurance Flexibility and Accountability (HIFA) waiver initiative in August 2001. HIFA waivers (also granted under the authority of Section 1115(a) of the Social Security Act) provide states with enhanced flexibility to expand Medicaid and SCHIP coverage within existing federal resources and place particular emphasis on broad statewide approaches that maximize private health insurance coverage options. While states may still choose to seek non-HIFA Section 1115 waivers, Section 1115 waiver requests submitted under the HIFA guidelines will be given priority review.

HIFA waivers continue to adhere to the longstanding federal policy that Section 1115 waivers must be "budget neutral" for the federal government – i.e., that the federal government will spend no more federal Medicaid funds than it would have spent without the waiver. Approved Section 1115 waivers, including HIFA waivers, have satisfied the budget neutrality requirement in several ways:

- By generating savings through managed care arrangements (although this method is less feasible now due to rising premium costs and the fact that many states have already implemented managed care);

[8] *42 U.S.C. 1315.*

[9] Ryan, J., "1115 Ways to Waiver Medicaid and SCHIP Rules," National Health Policy Forum, George Washington University, NHPF Issue Brief No. 777, June 13, 2002.

[10] Shirk, C., "*Shaping Public Prgrams Through Medicare, Medicaid and SCHIP Waivers: The Fundamentals,*" National Health Policy Forum, George Washington University, NHPF Background Paper, September 15, 2003.

- By redirecting Medicaid disproportionate share hospital (DSH) payments;
- By using unspent SCHIP allotments (known as "allotment neutrality" rather than budget neutrality), and
- By reducing benefits and imposing higher cost-sharing for some beneficiaries, beyond what is permitted under federal Medicaid rules.

Since the mid-1990's, CMS has also permitted "hypothetical program expansions" to be included in the "without waiver" budget neutrality base-year calculation. For example, if a state expansion group could have been added under current law without a waiver (such as low-income parents eligible under Section 1931 expansions – discussed below), the hypothetical expenditures for this expansion group can be included in the base-year calculation and therefore will automatically be deemed budget neutral to the federal government. Table 2 summarizes the various financing mechanisms for demonstrating budget neutrality that are used by currently approved HIFA waivers and by two pending HIFA waiver proposals.

Table 2: Financing of HIFA Waivers

	Savings Achieved through Changes for Pre-Waiver Groups				Federal Financing		State Financing	
State	Enrollment Cap	Benefit Reductions	New premiums/ enrollment fees	New cost sharing	SCHIP	DSH	Federal funds used to refinance preexisting state-funded program	Waiver replaces Medicaid funding with SCHIP funding
Approved								
AZ					√			√
CA					√			
CO					√			
IL					√		√	
ME						√		
NJ		√			√			
NM					√			
OR	√	√	√	√	√		√	
Pending								
AR					√			
WA	√	√	√	√	√		√	

SOURCE: Kaiser Commission on Medicaid and the Uninsured

As is clear from Table 2, thus far, HIFA waivers have predominately been accessed by states that had previously not fully expended their SCHIP allotments. Also, seven of the eight approved HIFA waivers allow states to use unspent SCHIP funds to expand coverage to adults – including

childless non-disabled adults who are not otherwise eligible for Medicaid coverage. Appendix B to this report summarizes the eight HIFA waivers approved to date.

As discussed above, currently Indiana's annual federal SCHIP expenditures exceed Indiana's annual federal SCHIP allotment although Indiana has substantial federal carry-over SCHIP funds and expects to continue to carry over federal SCHIP allotments for the next few years. Without future redistributions, however, Indiana will eventually run out of carry-over funds making it risky to plan a permanent coverage expansion that relies on SCHIP funds under the current SCHIP funding scenario. Despite the SCHIP funding limitations that Indiana faces, however, the experience of other states that have approved HIFA waivers (that rely on SCHIP funding) may nevertheless be instructive for Indiana. If Indiana can find another mechanism to satisfy the budget neutrality requirement, the flexibility that has been granted in currently approved waivers could be taken advantage of by Indiana as well.

Coordination with Employer-Based Coverage

With increasing state fiscal pressures and growing concerns over the rise in the number of uninsured, states have become increasingly interested in pursuing Medicaid reform options and coverage expansions that coordinate with and promote employer-based health coverage. States have found it administratively difficult, however, to implement "employer buy-in" programs while meeting all applicable Medicaid and SCHIP requirements. However, the new HIFA waiver initiative has significantly eased some of the administrative burdens of implementing an employer buy-in program. For example, CMS has been willing to approve HIFA waivers containing premium assistance programs for optional and expansion populations[11] that:

- Do *not* include "wrap-around" benefits (where the state provides Medicaid benefits not included in the employer's plan), and
- Do *not* limit beneficiary cost-sharing requirements.

HIFA waivers also place increased emphasis on coordination with private and employer-based coverage by specifically requiring that states include in their waiver application some form of integration of Medicaid and/or SCHIP funding with private health insurance funding.

New Mexico. The New Mexico State Coverage Initiative is the best example of an approved HIFA waiver meeting the original HIFA program goals to expand coverage and utilize unused SCHIP allocations, but also involve employers.[12] The New Mexico waiver expands coverage using unspent SCHIP funds through an innovative "reverse" employer buy-in program. Rather

[11] "Optional populations" are eligibility groups that a state can elect to cover, but is not mandated to cover, under its Medicaid program. "Expansion populations" are eligibility groups that do not meet Medicaid's categorical requirements (e.g., childless non-disabled adults) and could not be covered under Medicaid without a waiver.

[12] Presentation by Gretchen Engquist, *HIFA Design Issues and Future Challenges*, State Coverage Initiatives National Meeting, January 24, 2003.

than the state providing a health plan subsidy to either the employer or a direct premium subsidy to the employee, the employer would buy-into a new employer-sponsored insurance plan created and approved by the State. The state will contract with a managed care organization to provide a new insurance product for employers to offer to their low-income workers. The policy would be purchased with a combination of State and Federal, employer, and employee contributions and would be comparable to a comprehensive commercial benefit package.[13] Employers will be required to contribute at least $75 per employee per month toward premiums. (If there is no employer contribution, an employee would have to contribute the employer's share in addition to his or her own cost-sharing requirements in order to participate in the plan.)

Illinois. One component of Illinois' "FamilyCare" HIFA waiver is a refinancing of an existing state program that provided premium assistance for children – the "KidCare Rebate" program. Previously, the KidCare Rebate program covered children who were ineligible for SCHIP because they had private coverage at the time of application. KidCare Rebate enrollees receive a $75 per month subsidy (per eligible child) to be applied towards the purchase of employer-sponsored or other private coverage. As a result of the HIFA waiver approval, Illinois now receives federal matching funds (at the enhanced SCHIP rate) for this program and KidCare Rebate enrollees now have the option of seeking direct coverage (with full SCHIP benefits) in Illinois' regular SCHIP program (KidCare). The KidCare Rebate program has no wrap-around benefit requirements for the state. The private plans must include physician and hospital inpatient coverage, but there are no cost-sharing limits or employer contribution requirements. In July 2003, approximately 5,000 children were enrolled in the KidCare Rebate program.

Arkansas. Arkansas has submitted a HIFA waiver request (the "Arkansas Employer Sponsored Insurance Initiative") that proposes to expand coverage to up to 55,000 employed adults and their spouses. Arkansas would fund the program through employer taxes, federal SCHIP funds and beneficiary cost-sharing. Employers that voluntarily choose to participate would pay a "tax" that would be deposited into the state general fund and would be able to purchase a "bare bones" policy.[14] By employing the employer tax approach, Arkansas is hoping to obtain federal SCHIP matching funds on the employer's contribution. (In contrast, the New Mexico program contemplates a state contribution and only the state share would be matched by SCHIP – not the employer and employee contributions.) This HIFA waiver has not yet been approved, so it remains to be seen whether Arkansas' creative financing strategy will be allowed.

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[13] The implementation of New Mexico's HIFA waiver was placed on hold following the inauguration of newly elected Governor Richardson in early 2003. Thus, it is not yet possible to evaluate the effectiveness of this innovative approach. Governor Richardson has now endorsed the HIFA waiver plan and directed the New Mexico Department of Human Services to move forward on its implementation. A new target implementation date has not yet been made available. Telephone conversation on October 15, 2003, with Robin Hunn, an independent consultant that assisted with the development of the New Mexico HIFA waiver.

[14] The proposed benefit package includes seven inpatient hospital days per year, two outpatient hospital services per year (which includes emergency room visits), six physician visits per year, lab and x-ray services (when associated with a covered hospital or physician visit) and two prescription drugs per month.

Rhode Island. Rhode Island implemented its premium assistance program ("RIte Share") prior to the HIFA waiver initiative under the "regular" Section 1115 authority. The state initiated RIte Share after concerns arose that employers were dropping coverage following the expansion of Rhode Island's Medicaid eligibility for parents to 185 percent of the FPL in 1988. The state hoped that the RIte Share program would curb the explosive growth that was occurring in the regular Medicaid program (known as "Rite Care").

Families with incomes below 150 percent FPL have no cost sharing requirements while those with incomes above 150 percent must pay monthly premiums only. Families with access to employer-sponsored insurance can only choose RIte Share, but RIte Share covers all employer plan cost sharing requirements (in excess of required premiums) *and* provides wrap-around benefits for services not covered in the employer plan.

Rhode Island has worked hard to overcome administrative barriers and increase enrollment in Rite Share. Initially, RIte Share was designed to reimburse employers for the premium costs of RIte Share enrollees. The State, however, found it extremely difficult to persuade employers to participate due to the employers' reluctance to take on new administrative burdens. Therefore, Rhode Island changed the program to also allow premium reimbursements to be paid directly to the employee rather than the employer. The State reported in July 2003 that RIte Share had enrolled approximately 4,000 members as of the end of FY 2003, which represented approximately three percent of the combined RIte Care/RIte Share population.[15]

Premium Assistance Program Concerns. While a number of states are actively investigating, developing or implementing premium assistance programs using Section 1115 waivers, other states have determined that a premium assistance program would not be feasible. For example, after conducting a feasibility study, **Arizona** decided an employer sponsored insurance (ESI) pilot would not be feasible and cited the following concerns to CMS:

- The lack of employer based coverage for low-wage workers in Arizona (only one-third of small employers offer health coverage to employees in Arizona);
- Instability of the private insurance market in Arizona;
- Obstacles for beneficiaries (including a reduced benefit package, high cost sharing and a high degree of job mobility);
- State fiscal and administrative challenges, and
- Differences in delivery systems since the state's Medicaid program is operated almost entirely through HMOs and the ESI coverage might be provided through a fee-for-service system.

[15] "*RIte Share Premium Assistance Program Two Years Later,*" Kate Brewster, Rhode Island Department of Human Services, July 17, 2003, available at http://www.statecoverage.net/1703/brewster.pdf

CMS officials asked Arizona to reconsider its conclusions and submit a proposal for a pilot program. Negotiations continue over Arizona's response which was to propose a pilot in one rural county that would enroll only 50 people.

Refinancing State Funded Programs

Following the introduction of the HIFA waiver, states soon began exploring HIFA as a potential strategy to access the enhanced SCHIP federal matching rates to expand coverage by supporting already planned expansions or to federalize state programs.

Arizona. Arizona used its HIFA waiver to help finance a Medicaid eligibility expansion mandated by a ballot initiative. In 1996, Proposition 204 passed, raising the income eligibility level for the Arizona Health Care Cost Containment System ("AHCCCS" – Arizona's Medicaid program) from 34 percent of the Federal Poverty Level ("FPL") to 100 percent of the FPL and also required coverage for childless adults up to 100 percent of the FPL. Using a HIFA Waiver enabled Arizona to leverage federal Medicaid funding for the childless adults (who are otherwise not eligible for Medicaid) and also access the enhanced SCHIP federal matching rate and fully utilize the state's SCHIP allocation.[16]

Illinois. As noted earlier, Illinois' FamilyCare HIFA waiver includes the refinancing of the previously state-funded KidCare Rebate program. In its HIFA waiver, Illinois also refinanced coverage for participants in the Illinois Comprehensive Health Insurance program and in Illinois' Hemophilia program with net incomes up to and including 185 percent of the FPL, who are not eligible for Medicaid coverage and do not have Medicare or other health insurance coverage.

The Oregon Health Plan 2, Utah's Section 1115 waiver and the pending Washington HIFA waiver request (each discussed below) also include the refinancing of previously state-only funded programs.

Waivers to Expand Coverage *and* Control Medicaid Expenditure Growth

Oregon Health Plan 2. With state fiscal conditions in their worst shape since World War II[17], states are now questioning how far the Centers for Medicare and Medicaid Services ("CMS") would be willing to go to allow a HIFA waiver to be used as a budget management device, even as it is also used to expand coverage to some degree. Oregon was the first state that sought true management tools under HIFA including flexibility to adopt a benefit package that could be

[16] Under the Arizona waiver, expansion populations will receive the full Medicaid benefit package through the state's contracted health plans, with the co-payment structure now in place. Parents with incomes between 100 percent and 200 percent FPL will be subject to the premium and co-payment schedule established for SCHIP employee package. Cost-sharing is consistent with federal SCHIP requirements.

[17] *The Fiscal Survey of States,* November 2002, National Governors Association and National Association of State Budget Officers.

adjusted downward to a Medicaid minimum as well as the imposition of copayments and premiums approaching the commercial market.[18]

Oregon received approval in October 2002 to restructure the Oregon Health Plan ("OHP") – Oregon's Medicaid demonstration program (initially implemented in 1994) that serves approximately 380,000 Oregonians. Oregon's HIFA waiver (the "Oregon Health Plan 2," or "OHP2") enables Oregon to utilize its unspent SCHIP funds and restructure the Oregon Health Plan into three distinct benefit packages. As originally conceived, the three benefit packages had the following characteristics:

- *OHP Plus* would apply to all mandatory Medicaid populations and some optional populations (including pregnant women and children up to 185 percent of the FPL) and would provide a comprehensive benefit package equivalent to that offered through the original OHP;
- *OHP Standard* would cover low-income adults initially up to 100 percent of the FPL but eventually up to 185 percent of the FPL.[19] This would include the parents of children enrolled in Medicaid and SCHIP and childless adults as well as seniors and people with disabilities with incomes at or above 75 percent of the poverty line. A reduced benefit package would be offered budgeted at approximately 78 percent of the actuarial value of the OHP Plus benefit plan[20] but capable of being reduced (by eliminating optional services) to 56 percent (a level equivalent to the cost of the mandated minimum Medicaid benefits that states must provide absent a federal waiver) if necessary for budget reasons; and
- *The Family Health Insurance Assistance Program ("FHIAP")* was a previously existing state-funded premium assistance program created in 1997. The FHIAP has been folded into the OHP2 HIFA waiver enabling Oregon to receive federal matching funds. The FHIAP would be available to families and individuals with income up to 185 percent of the FPL and would provide premium assistance on a sliding-scale basis for employer-sponsored insurance.

OHP Plus enrollees pay only nominal copayments and no premiums. Copayments for OHP standard enrollees vary based on services and income level and include:

- $250 per inpatient hospital admission;

[18] Engquist, January 24, 2003.

[19] Implementation of the OHP2 waiver included the transfer of 110,000 non-categorically eligibile adults below the poverty line into the OHP Standard Plan.

[20] OHP Standard benefits were originally intended to be consistent with commercial health insurance coverage and included inpatient/outpatient hospital services, emergency room treatment, physician services, lab and x-ray, ambulance, pharmacy, mental health/chemical dependency, durable medical equipment and dental services. Vision and non-emergency transportation services are not included. *Oregon Health Insurance Flexibility and Accountability Initiative Fact Sheet available at www.statecoverage.net/reportsearch/stateresult.cfm.*

- $20 per surgery and $5 for outpatient services;
- $5 per office visit and $3 - $10 for medical and surgical procedures;
- $ 3 for each lab and x-ray;
- $2 - $5 for each generic drug, $3 - $10 for each mental health/cancer/HIV brand drug, and $15 - $25 for other brand name drugs.

OHP standard enrollees are also required to pay premiums (varying by income) ranging from $6 to $20 per month per individual.

The OHP2 program was originally expected to expand coverage to 60,000 people (some of whom were previously covered under the state-funded FHIAP). The planned expansions included expanding OHP Plus to children and pregnant women between 170 percent and 185 percent FPL and eventually expanding OHP Standard to adults between 100 percent and 185 percent FPL. However, severe fiscal conditions have caused Oregon to repeal the expansion authority for the OHP Standard plan and also scale back the OHP Standard benefit package.[21] In November 2002, the Emergency Board of the Oregon Legislature removed coverage for mental health and chemical dependency services, dental benefits and durable medical equipment.[22] Prescription drug coverage was temporarily cut (for 13 days) in early 2003. In FY 2004, Oregon plans to seek federal approval to make additional benefit reductions in the OHP Standard plan. Specifically, Oregon would convert the OHP Standard benefits package into a primary care package by eliminating non-emergency hospital services, therapies and home health services while also restoring coverage for mental health and chemical dependency services as well as medical supplies and emergency dental services.[23] On the positive side, Oregon is also planning to expand SCHIP coverage (under the OHP Plus plan) and coverage under the FHIAP plan to 200 percent FPL in FY 2004.

Other interesting features of OHP2 include:

- Persons eligible for OHP Plus may make an informed choice to receive premium assistance through the FHIAP rather than receive the more comprehensive OHP Plus benefits and the State is *not* required to provide additional wrap-around coverage;
- Providers will be allowed to refuse treatment to OHP Standard enrollees who refuse to comply with the copayment requirements. No other state has implemented such a policy in their program due to federal Medicaid requirements that services may not be withheld due to inability to satisfy copayment requirements.[24]

[21] Oregon also eliminated its "medically needy" program in FY 2003.
[22] *State of the States: Bridging the Health Coverage Gap,* Robert Wood Johnson Foundation State Coverage Initiatives Program, January 2003, p.18.
[23] V. Smith, et al, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2004,* Kaiser Commission on Medicaid and the Uninsured, September 2003.
[24] *State of the States, Bridging the Health Coverage Gap,* p. 19.

Washington Reform Waiver. One pending (not yet approved) HIFA waiver that has received considerable attention was submitted by the State of Washington. While the Washington waiver would expand coverage for 20,000 parents and childless adults, the waiver is also intended to help address the state's budget crisis by slowing the growth in the state's health care expenditures. Like Oregon, Washington is proposing to use the HIFA waiver to access unspent SCHIP funds to refinance a state-funded health care program – Washington's Basic Health Plan ("BHP"). The waiver proposal also includes new copayment requirements for all enrollees (except Native Americans and Alaskan natives) and new premium requirements for higher income enrollees ranging from $10 to a family maximum of $60 per month (except for Native Americans, Alaskan natives and Medically Needy enrollees). Higher income adult enrollees would have a reduced benefit package that excludes routine hearing and vision care, non-emergent dental care and dentures. One other interesting feature of Washington's HIFA request is an enrollment freeze. Washington is seeking approval to freeze enrollment in certain optional eligibility categories based on state caseload and expenditure forecasts. The enrollment freeze would apply only to "new" applicants seeking coverage in "frozen" program categories.

Utah 1115 Waiver. In February 2002, CMS approved a landmark 1115 Medicaid Waiver for the State of Utah. The Utah waiver plan was implemented in July 2002. This waiver was not approved as a HIFA waiver, but it is similar to a HIFA waiver in that it seeks to expand health care coverage by restructuring the existing Medicaid program. What has made this waiver controversial is that it expands limited primary care coverage to 25,000 adults up to 150 percent of the FPL by adopting a reduced benefit package (the "Non-Traditional Medicaid Plan") for 17,000 – 20,000 adults including some mandatory Medicaid beneficiaries (rather than only optional and expansion groups). The State is financing the waiver by folding in the state-only Utah Medical Assistance Program and by using the savings from the Medicaid benefit reductions and new cost-sharing requirements.

The Non-Traditional Medicaid Plan originally excluded coverage for speech, audiology, podiatry, non-emergency dental services, and non-emergency transportation. There is also a cap on the number of physical therapy, chiropractic and psychiatric visits and a $30 per year limit on vision care.[25] The new "Primary Care Plan" for the expansion population consists of basic primary and preventive care services including physician office visits, immunizations, emergency care, lab, x-ray, medical equipment and supplies, basic dental care, hearing and vision screening, and prescription drugs. Hospital care is limited to only emergency services. Enrollees will pay a $50 enrollment fee, and will also have copayment and coinsurance requirements. Total

[25] Due to state budget pressures, additional benefit reductions were made in FY 2003 (including elimination of vision care services) followed, however, by some benefit restorations in FY 2004 (including speech therapy, audiology and limited podiatry coverage). V. Smith, et al, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2004,* Kaiser Commission on Medicaid and the Uninsured, September 2003.

out-of-pocket costs per year are limited to a maximum of $1,000. While the Primary Care Plan does not include inpatient hospital services, enrollees will be able to access certain donated medical services in the community including $10 million of donated hospital care, specialty care offered in an inpatient setting, donated outpatient specialty care, health education services and referrals to prescription assistance programs.

Medicaid Expansions Using Section 1931

Section 1931 of the Social Security Act was established as part of the 1996 federal welfare reform that replaced the Aid to Families with Dependent Children (AFDC) program with the Temporary Assistance for Needy Families program (TANF). Section 1931 "de-links" Medicaid coverage from welfare coverage by requiring states to provide Medicaid coverage to parents in families that meet the AFDC eligibility requirements as they existed on July 16, 1996, whether or not those families receive assistance from TANF. States also have the option under Section 1931 to expand eligibility for these parents through the use of "less restrictive" income and resource methodologies.[26] As of 2000, 27 states had used Section 1931 to expand eligibility by changing the way that income is counted.[27]

As an outgrowth of recommendations made by the Health Insurance for Indiana Families Committee in 2001, legislation was enacted in 2001 that authorized a coverage expansion for parents of the Indiana Medicaid Hoosier Healthwise program. This expansion was to be accomplished under Section 1931 but was also contingent on other hospital Medicaid financing initiatives that ultimately could not be implemented. Thus, the expansion was never implemented.

Prospects for Federal Medicaid Reform

Over the past year, there has been considerable discussion at the federal level concerning the need to reform the Medicaid program to assist states in controlling expenditure growth and thereby maintain coverage levels. The discussion intensified in January 2003, when the Bush Administration proposed sweeping financing and programmatic changes to the Medicaid program and to the SCHIP program. The President's proposal essentially tied immediate fiscal relief for states to the restructuring of Medicaid and SCHIP. States would have had the option to operate their Medicaid programs as they had in the past or to accept a capped grant of $12.7 billion over seven years by entering into an agreement with the federal government. The President's proposal required a continued financial commitment on the part of states, often referred to as a "maintenance of effort" (MOE) requirement. Like the federal contribution, the state MOE would have increased annually, but the rate was designed to grow more slowly than the federal contribution. Under the Bush reform proposal, states participating in the block grant

[26] *The Medicaid Resource Book,* Kaiser Commission on Medicaid and the Uninsured, July 2002.
[27] www.statecoverage.net/medicaid-1931.html.

program would *not* have been subject to existing federal rules regarding the benefit package, cost-sharing, enrollment, and other features of the program. Although there would have been some protection for "mandatory" beneficiaries, states would have been be able to design individual programs for "optional" beneficiaries.

The Bush reform proposal failed to receive the support of the nation's governors who had a number of concerns. In particular, governors were concerned that the amount of money provided by the federal government would increase over the first several years, but the program would be budget neutral over a ten-year period. This implied that the level of funding that states would receive would be lower towards the end of the ten-year window. Governors and others were also concerned that such factors as rising health care costs, increases in expenditures due to increased enrollment and utilization might not be accounted for in the amount of spending that is allocated to states, and that states would then have funding constraints which might result in eligibility and benefit cuts, and other difficult choices that states have had to make in light of Medicaid budget shortfalls that states are currently experiencing.

Rather than take up Medicaid reform legislation, the Congress, in June 2003, instead enacted a temporary increase in the federal Medicaid matching rate to provide $10 billion in fiscal relief to states in fiscal years 2003 and 2004. The legislation (The Jobs and Growth Tax Relief Reconciliation Act of 2003) also provided a total of $10 billion in temporary grants for states to use for Medicaid or other state programs. While the increased federal funding has been greatly appreciated by and helpful to states, concerns are mounting as state Medicaid and budget officials are now planning for how to make up for the expiration of these new funds that will occur on June 30, 2004.

In a recent Congressional hearing on the issue of Medicaid reform, there continued to be no evidence of any bipartisan consensus on the possible future shape of Medicaid reform legislation. Further, CMS representatives could not say whether the Bush Administration would bring forward its Medicaid reform plan again next year. Thus, it is unclear whether Medicaid reform will come to the forefront again in 2004.[28] Rather than focusing on coverage expansions, much of the discussion in 2003 appeared to be framed as a need to reform Medicaid to enable states to maintain current coverage levels.

[28] J. Reichard, *Washington HealthBeat,* October 8, 2003.

Health Insurance Market Reforms and Initiatives

In considering how insurance reforms might expand coverage to the uninsured, it is useful to categorize the uninsured into four groups:

1. People who could afford to buy coverage but choose not to do so. Only some kind of mandate is likely to induce these people to acquire coverage.
2. People who are eligible for existing subsidy programs but do not take advantage of them. These people may be induced to enroll by an effective outreach program or by policies that reduce the stigma attached to participating in the subsidized programs.
3. People who cannot afford coverage that is available in the private market but who pose no special risk to insurers because of their health status or other personal characteristics. Generally speaking, these people will require subsidies of some sort. Reforms of the insurance market unaccompanied by subsidies are likely to have only modest effects in increasing coverage among this group.
4. People who could afford to buy coverage at the average rates available in the market but who are seen by insurers as high risk because of their health status or other characteristics and thus face high premiums. Most insurance market reforms are aimed at making coverage more affordable for these individuals.

For the most part, then, insurance market reforms are designed to help people who are seen by insurers as having characteristics that make it likely that they will consume a disproportionate amount of health services and thus will be unusually expensive to insure. Typically, the problem is approached by finding ways to spread the higher risks that these people represent more broadly over the insured population. One approach is through regulation or other government-mandated policies that requires insurers to charge these people lower rates than they would do voluntarily in the absence of regulation. Assuming that the rates insurers would have charged these high-risk people were accurate reflections of the medical costs they would incur, the insurers will have to recover the lost premium revenue by charging higher rates to lower-risk people.

For several reasons, insurance market reforms are unlikely to lead to large reductions in the number of uninsured. First, the number of people with unusually high-risk characteristics is a relatively small portion of the uninsured population. Second, when reform requires insurers to lower rates for high-risk people and they respond by increasing rates for lower-risk populations, some lower-risk people will decide to drop coverage. This does not mean that insurance reform is not worth doing. It makes the system fairer in the sense that high-risk people are not prevented from getting insurance because of conditions that are generally beyond their personal control,

and it is a way of providing coverage to the people who are most likely to have high medical expenses and hence most need the financial protection that health-insurance provides. Even if the consequence is that some low-risk people drop coverage, they are the least likely to incur financially burdensome health care expenses.

We turn now to specific insurance market reforms.

Guaranteed Issue

Before the days of insurance market reform, it was not unusual for insurers simply to deny coverage to individuals or groups that insurers classified as unusually high risk. States and the federal government responded to this problem by passing guaranteed-issue laws. As a consequence, in the small-group market, coverage denials are prohibited under federal law as well as most state laws. Insurers are required to provide coverage on a guaranteed-issue basis to all applicants. (It is important to note that guaranteed-issue laws without regulations to limit insurers' ability to vary premium rates, as discussed below, are ineffective. If insurers can charge high-risk people extremely high rates, they effectively deny people the ability to buy coverage.)

Although a number of states require insurers to provide coverage on a guaranteed-issue basis in the individual market, this is not as common as in the small-group market. In 2001, 16 states had laws requiring some form of guaranteed issue in the individual market, although in many instances there were limits on the coverage that was available.[29] States are sometimes hesitant to require guaranteed issue in the individual market because of the peculiarities of that market. Because health insurance is expensive and because individuals can predict with some degree of accuracy when they need expensive medical care, individuals may choose to go without coverage when they do not anticipate needing care and buy coverage only when they expect to incur large medical expenses. Such behavior is inconsistent with the insurance principle, which is based on the assumption that risk is spread over a large group of individuals, any one of whom is unlikely to incur high medical bills. Providing individual coverage on a guaranteed-issue basis allows such individuals to avoid paying their fair share of the insurance bill, which raises premiums for everyone who does buy coverage. Besides being unfair, the result is that some individuals drop coverage.

Whether guaranteed issue (paired with sufficiently rigorous rating restrictions) can be effective in the individual market remains to be seen. New Hampshire recently repealed its law requiring guaranteed issue in the individual market.[30]

[29] Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-risk Health Insurance Pools,* Commonwealth Fund, August 2001, Table 11.
[30] State of the States.

Rate Bands and Other Rate Restrictions

One of the most obvious ways to make coverage more affordable for high-risk people is to limit the extent to which insurers can vary premium rates based on characteristics of the insured individuals or groups. The extreme form of rate compression regulation is pure community rating, which requires insurers to charge the same premium rates to everyone applying for a specified benefit package. A few states require pure community rating in both the small-group and individual markets, but states have generally shied away from this policy for fear that the increase in premium rates for low-risk individuals and groups would cause too many people to drop coverage. A less extreme form of rate compression is adjusted community rating. States that use this approach, which is more common, allow insurers to vary rates somewhat, but they typically prohibit the use of certain characteristics, particularly previous medical conditions or current health status, and they place a limit (or impose "rate bands") on the amount of variation that is permitted. Commonly, rating is permitted for age, gender, and geographic location.

Assessments of community rating in its various permutations have found that this type of insurance reform has little effect on the total number of uninsured. In hindsight, this is not a particularly surprising result since a relatively small proportion of the population has characteristics that put them in the high-risk category. On the other hand, the evaluations have also generally concluded that modified community rating and its permutations have not caused major market disruptions, at least in the small-group market, and have made the system more acceptable in the public view. At least in the small-group market, the fears that rate compression would cause large numbers of relatively low-risk people to drop coverage have proved unfounded.[31]

Although most states regulate rate variation in the small-group market, the restrictions vary widely. In some states, rate variation ratios of six to one or even more are permitted, whereas other states require pure community rating. Fewer states (17 in 2002[32]) impose such rating reforms in the individual market. States have been more reluctant to pass individual market reforms because of peculiarities of the individual market discussed earlier.

Several states with tight rating rules have recently experienced declining enrollments in their small-group markets, among them Colorado and New Jersey.[33] While critics of rate regulation attribute the decline to the rating laws, so many other factors have changed during the period that rate regulation has been in effect that it is difficult to determine a cause-and-effect relationships. One state, Michigan, in late 2003 passed legislation that imposes constraints on insurers' ability to vary rates based on small-group characteristics.

[31] Mark A. Hall, An Evaluation of Health-Insurance Market Reforms: Summary Findings, 1999, http://www.phs.wfubmc.edu/pub_insurance/pub_insur_summary.cfm
[32] Achman and Chollet.
[33] SIC

High-Risk Pools in the Individual Market

As an alternative to rate reform and guaranteed issue in the individual market, some states have adopted a high-risk pool. These pools are a form of last-resort coverage for people who have medical conditions or other characteristics that make them uninsurable in the eyes of insurers. In other words, insurers conclude that they could not afford to provide coverage for these individuals except at rates so high that coverage would be completely unaffordable. One solution is to separate out these individuals from the rest of the insured population and put them together in a special pool that provides coverage at subsidized premium rates—that is, the premium revenues do not cover the costs of providing the medical services that this group uses.

It is important to recognize that this approach, like virtually all others that seek to reduce premiums for high-risk people, requires that the costs be spread over the normal-risk population. Since the premiums for those in the high-risk pool are subsidized, the shortfall has to be made up by collecting revenue from other than the high-risk people themselves. Typically, states have generated the revenues by assessing fees on other insurers in the state. The insurers, of course, pass on these additional costs in the form of higher premiums to the individuals and groups they insure, thereby raising premiums for this population. The consequence is likely to be that a few people who are on the margin of buying coverage decide that they no longer can afford it.

One of the problems of assessing other insurers is that federal law (ERISA) prohibits states from requiring self-insured employers to pay such fees; so the subsidies are financed from the smaller employers that are not self insured and the people who buy coverage in the individual market. Not only is this not an equitable distribution of the burden; it also places a practical limit on the amount of revenue that can be collected.

Another approach to financing the subsidies is to use more broadly based revenues. A number of states impose fees on hospitals and or other providers. This is a mechanism for spreading the risk more broadly among most of the insured population, since providers pass on that these fees in the form of higher reimbursement charges, and these are, in turn, reflected in higher premiums for both insured and self-insured groups.

High-risk pools, for the most part, have not been very successful in reducing the number of uninsured. As noted earlier, one reason is that a relatively small portion of the population is in the high-risk category; high-risk pools are not designed to meet the needs of the average-risk uninsured. But even when they are evaluated only in terms of their success in meeting the needs of the high-risk population, pools have experienced a number of difficulties:

- While subsidized, the rates are often still too high to be affordable for many of the people who qualify for participation. Rates tend to range from 125 percent to 200 percent of the rates for standard coverage. One recent study concluded that premiums range from 4 percent to 12 percent of median household income. The average premium was 8.1 percent of median household income.

- Even though premiums are often high, coverage may not be comprehensive; the benefit structure may include high deductibles and substantial consumer cost sharing. Typically, there are limits on coverage for pre-existing conditions.
- High-risk pools are often underfunded. As a consequence, either some people who are eligible to participate are put on waiting lists and left without coverage, or the premiums are so high that many people for whom the program is designed cannot afford the coverage.

One study summarized the experience as follows: "As a result of costs, restrictions on benefits, and waiting periods, state high-risk pools insure an average of 1.2 percent of those covered by individual insurance—less than 2 percent in all but three states (Minnesota, Nebraska, and Oregon)."[34]

One state, Maryland, began operating a high-risk pool in 2003. Coverage will be available to people who can show proof that they have been turned down for individual coverage. State authorities anticipate that the maximum premium will be no more than 150 percent of the standard rate. The funds to finance the pool are generated from a special assessment on hospitals. This amounts to spreading the risk among all users of the hospital system. (Maryland is unique among states in having a hospital "all payer" rate-setting system that charges uniform rates to all payers, including Medicare.)

Stop-loss Coverage

Insurance premiums could be lowered if insurers did not have to cover the medical costs of very expensive episodes of care. As noted elsewhere, about 10 percent of any population group accounts for about 70 percent of the medical costs in any year.[35] If the insurers could pass on some or all of the costs of the few very high-cost cases to some other entity, they could offer substantially reduced premiums to the rest of the population, which would cause more of the uninsured to purchase coverage.

Many insurers already protect themselves against the catastrophic cases by passing on the risk to other insurers who sell "stop-loss" coverage or reinsurance. The reinsurers charge the insurance company a premium for absorbing the risk of paying a portion of the cost of very high-cost cases. But, of course, the cost of that premium is passed on by the original insurers in the premiums they charge their customers. In essence, all of the costs of the highest cost medical cases are borne by the population that buys traditional health coverage.

Now, if a substantial portion of the costs of the most expensive episodes of care were covered by some other mechanism—for example, a government fund—insurers could charge lower premiums. Of course, there is no free lunch: in that case the cost would be passed on to whoever

[34] Achman and Chollet.

provides the revenue that supports the government fund, presumably, taxpayers. If the revenue for the fund comes from a broadly based, non-regressive tax, this may be a more equitable way to pay for these costs than to have them absorbed only by the people covered by fully insured health plans (and not those covered by self insured plans), as normally would be the case.

One state, New York, has tried this approach on a small-scale. A program called Healthy New York incorporates a state-financed stop-loss fund that pays for up to 90 percent of the cost for enrollees who incur medical expenses between $30,000 and $100,000 in a year. The coverage is available only to lower-wage small employers and lower-income individuals. To be eligible, at least 30 percent of the employees in a business with 50 or fewer workers must earn no more than $30,000 per year, and sole proprietors and individuals must have household incomes that are below 250 percent of poverty level. They also must not have had health-insurance coverage in the previous 12 months. The coverage offered as part of this program is significantly less comprehensive than is currently available in New York's individual or small-group market; some state mandates are waived, and consumer cost sharing is higher than is typical. Finally, coverage must be obtained through HMOs. The early experience was that premiums were substantially lower—up to 50 percent lower in the individual market and about 15 percent to 30 percent lower than the small-group market.[36]

"Bare Bones" or Pared-Down Benefit Packages

It is reasonable to assume that if health-insurance premiums could be reduced, some who are now uninsured would buy coverage. A possible way to lower premium prices would be for insurers to offer benefit packages that are less comprehensive than is typical of most coverage sold today.

"Catastrophic" Coverage

One approach is to encourage the sale of "catastrophic" coverage. Such coverage would incorporate large deductibles—for example, $1,000 or $1,500 per year per person—and perhaps substantial other consumer cost sharing as well—for example, 30 percent of the cost of services once the deductible has been met (up to some limit). The services covered under the plan might or might not be similar to those covered in a typical current insurance policy, but the insurance company would not begin to pay until the consumer had absorbed a large cost.

Proponents of this kind of coverage (which is an element in medical savings accounts and "consumer driven" health care plans) often argue that typical coverage does not give consumers sufficient incentives to be cost-sensitive. The insurer pays much of the bill regardless of whether

[35] Marc L. Berk and Alan C. Monheit, "The Concentration of Health Expenditures, Revisited, Health Affairs, March//April 2001, pp. 9-17.
[36] Katherine Swartz, Healthy New York: Making Insurance More Affordable for Low-income Workers, the Commonwealth Fund, Nov. 2001.

the cost is relatively small or large. The function of insurance as traditionally conceived is to cover large, unpredictable losses—medical expenses too large for any but very high-income people to pay without incurring an unmanageable financial burden. Yet health coverage prevalent in today's market covers relatively small, predictable expenses, such as routine physician visits or allergy shots—expenses that most people could easily budget for and pay for from their own resources. If they had to pay for these services out of pocket, consumers would be more likely to economize, the supporters of the catastrophic approach believe.

Research evidence indicates that there is some validity to the arguments of the supporters of catastrophic coverage: higher cost sharing does encourage lower utilization. But the critics offer several countervailing arguments. First, they note that the research shows that people are as likely to avoid consuming *necessary* services as unnecessary services. The consequence may be that their health suffers, particularly if they fail to get needed preventive care or treatment for chronic conditions, which in the long run may actually increase medical spending. Second, they point out that the bulk of medical expenses are incurred by a few very sick people. The rough rule of thumb is that out of any population, about 10 percent will account for about 70 percent of the medical expenses in any year. Even under a catastrophic coverage plan, these very ill people would have reached the point where the insurance pays most, if not all, of the costs. This has two implications: (1) For the people who account for a large proportion of the costs, the economizing incentives will no longer operate. (2) It is questionable whether catastrophic coverage would be dramatically less expensive than more comprehensive benefit packages, since the very high-cost episodes of care would still be a liability for the insurer and would be reflected in premiums.

There is a practical concern about encouraging insurers to sell catastrophic coverage. There is substantial evidence that the market for such policies is small. During the 1990s, many states undertook insurance reforms that made "basic" health plans available in the small-group market for the first time. While not exactly catastrophic coverage plans, the "basic" plans were substantially less comprehensive than the plans that were typically offered. The consistent experience was that these did not sell well. Few employers or individuals found them attractive. To date, the experience with medical savings accounts (MSAs) has been similar; they account for only a tiny portion of health insurance sales. The fact that limited benefit packages are not popular with consumers should not be too surprising. People correctly think that their chances of incurring a catastrophic medical expense are small, but they know that they are very likely to need a number of more-or-less routine medical services, the cost of which in total can be significant. Because health insurance has typically paid a portion of these costs, they view insurance that does not do so as being inferior and inadequate.

There is also some reason to be concerned that catastrophic coverage would appeal primarily to people who are at low risk of needing appreciable medical care. If they are unusually healthy, they are likely to want to protect themselves against very large medical expenses, but they don't anticipate needing much in the way of more-or-less routine care. On the other hand, people who anticipate needing a good deal of medical care are not likely to buy catastrophic coverage. The

consequence could be risk segmentation: high-risk people buy one sort of coverage, and low-risk people buy another. The departure of many low-risk people from the risk pool would cause premiums to rise for high-risk people, making coverage unaffordable for some.

"Front-end" Coverage

A very different approach to limited benefit packages is coverage that would pay for a significant portion of the costs of primary care, some prescription drugs, and limited laboratory and specialty services but which would not cover the very high-cost episodes associated with an acute-care hospital stay and or similar expensive medical event. Such coverage is definitely not insurance in the traditional sense, but it would clearly be less expensive than a traditional insurance plan. And it could provide low-income people with access to the preventive and primary care they need and value, thereby helping them to avoid expensive episodes of care that result from not having received attention before conditions become serious. Of course, people with this kind of coverage would be forced to fall back on the safety net system if they did need very expensive care, but that is what they do already. At least if they have this kind of limited coverage, not all of the expenses they incur become a burden on the safety net system.

Insurers are likely to be wary of offering this kind of coverage because of the dangers of adverse selection. The people who are most likely to buy this kind of coverage are those who expect to consume substantial amounts of the covered services. The premiums, therefore, are likely to be higher than they would be if those who bought such coverage represented a cross-section of the population.

In many states, insurance regulations would prohibit the sale of such coverage because it would exclude coverage for many mandated benefits. But if the coverage had to include all the mandated benefits required by legislation, the purpose of offering the coverage would be thwarted. It is a question whether the political will would exist to waive the mandates for this kind of coverage. Legislators, insurance regulators, and patient advocates may object to permitting the sale of coverage that is clearly not adequate financial protection and thus not appropriate for middle- and higher-income people. Allowing it to be sold for may be seen as setting a bad precedent.

Ingham County in Michigan has successfully implemented in a program that offers this kind of limited coverage.

Purchasing Cooperatives/Insurance Exchanges

A high proportion of uninsured people are employed by small businesses. If a way could be found to induce more of these small firms to offer coverage, coverage rates might improve. Unfortunately, small businesses typically pay even more than large firms for health coverage, partly because insurers experience diseconomies of scale in serving small employers and because

individual small employers have no bargaining power with insurers and thus can't negotiate more favorable conditions and rates. Several states and some municipalities have sponsored efforts to form health-purchasing cooperatives (HPCs) so that small employers can pool their purchasing power and collectively purchase health coverage. The expectation is that with the purchasing clout of many small employers purchasing collectively, the HPC will be able to do what large employers do: bargain for better premiums and realize administrative savings, thus making coverage more affordable.

On the surface, at least, the purchasing cooperative idea has considerable appeal:

- Though states (or municipalities, such as New York) normally provide start-up money, the cost is relatively small;
- This approach tends to be politically palatable to people of different philosophical perspectives, though insurers and insurance agents may oppose it;
- HPCs make it possible for an employer to allow individual employees to choose different health plans rather than forcing everyone to enroll in a single plan chosen by the employer, and
- Once they become fully operational, most HPCs support their operations from fees added to premiums, so the cost to government is quite low and limited to perhaps supporting the effort with start-up funds.

On the other hand, analyses of existing HPCs suggest that they are not the solution to the problem of the uninsured. The evidence is that few, if any, HPCs are able to offer products at prices significantly lower than those generally already available elsewhere in the market. The inability to offer a lower price is due in part to the fact that most HPCs have not been able to capture a large market share and thus become large enough to have clout or realize administrative economies of scale. Even in California, which has the largest HPC, the total number of people enrolled (currently about 150,000) represents only a small share of the small group market. Persuading small employers to use HPCs as their source of coverage has proved to be difficult. One reason is that they depend upon insurance agents for advice in purchasing coverage, and agents generally have not been enthusiastic about HPCs, perhaps because they fear that if the cooperative became very successful, they might not need agents. It has also been difficult to persuade health plans to continue to participate in HPCs. They do not see them as a significant source of profits because they don't represent a substantial share of total business. In addition, insurers are understandably reluctant to promote an approach that gives their customers greater bargaining power.

But even if HPC were very successful, they almost certainly could not produce price reductions sufficient to attract large numbers of the uninsured, many of whom would still need subsidies. Even the most optimistic supporters of HPCs did not expect that they could reduce premiums by more than 10 percent or 15 percent, and such a reduction is insufficient to cause large numbers of

small and employers to begin offering coverage. The State of Maine's "**Dirigo Health Plan**" that will be implemented in July 2004, however, will combine low-income subsidies with a state created not for profit organization (Dirigo Health) that will contract with insurance carriers to provide a comprehensive benefit to individuals, self-employed persons and small businesses and municipalities. In the first year of the program, the subsidies will be funded with one-time funds including funding from the recently enacted federal fiscal relief for states (contained in the Jobs and growth Tax Relief Reconciliation Act of 2003). In later years, the subsidies will be funded from "savings offset payments": payments by health insurers pursuant to assessments made by the state of Maine that will reflect savings from reduced charity care and bad debt expenses. Maine hopes to expand coverage to 31,000 individuals in FY 2004 and 110,000 individuals by 2009. An overview of Dirigo Health is attached as Appendix C.

At least as traditionally envisioned, HPCs will have a harder time operating if state laws permit insurers to charge widely differing premiums to low-risk and high-risk groups. Indiana's law limiting the amount by which insurers can vary rates between high-risk and low-risk groups (known as "rate bands") allows relatively wide premium variation.

HPCs are often seen as a possible way to promote broader risk pooling. They cannot achieve this objective, however. They cannot be more permissive in accepting high-risk groups or in pooling risks in setting premiums than the market is generally; if they do, they will become victims of adverse selection—that is, they will end up with all the high-risk groups and thus have to charge very high premiums.

The most fundamental problem with HPCs is that they have been unable to become large enough to realize economies of scale or to have bargaining power. One way to address this problem would be for states to require that insurers who wish to serve small employers must sell coverage only through a HPC. For example, the state might make a HPC the only source of coverage for employers with 15 or fewer employees. Insurers could continue to compete with one another on the basis of price and service, but all of their sales would be through the HPC.

Association Plans

For a number of years, Congress has debated the wisdom of endorsing "association plans" as a mechanism to help small employers purchase coverage more economically. The supporters note that there are many existing associations of employers that already have a structure in place and a relationship with a receptive group of potential customers. By offering coverage to their members, the association would be aggregating the purchasing power of many small employers to realize economies of scale and give small employers bargaining power with insurers. In some respects, the concept is similar to HPCs, but there are important differences. Association plans would be permitted to self-insure, just as large employers do, and presumably reap some of the benefits that self-insurance provides. HPCs are normally open to any small business, whereas association plans would offer coverage only to businesses that are members of the association.

Supporters of the association plans have also sought federal legislation that would preempt state mandated benefit laws so that they could offer a less comprehensive benefit package than is now possible. Not having to conform to each state's mandated benefit laws would make it easier for associations to operate nationally and, it is argued, would allow them to sell coverage that is less comprehensive and therefore less expensive. In some versions of the proposed legislation, insurance commissioners would have very limited powers to regulate these entities, and association plans would not be subject to premium taxes.

The critics of association plans see them as a subterfuge to get around the state insurance reform laws, in particular the laws that limit insurers' ability to vary premiums based on characteristics of small-employer groups. They argue that only associations whose members include a disproportionate number of low-risk people would have incentives to form such a plan. By pooling only their own low-risk members, they would not be sharing risk with the rest of the population, which includes both high-risk and low-risk people. Therefore premiums would be lower. But, of course, when low-risk people are able to separate themselves out from the rest of the population, the average risk of the people remaining in the larger pool increases, and insurance premiums rise as a consequence. The premium reduction enjoyed by those in the association plans would be offset by a premium increase for those outside the association plan. The fear is that the purpose of the rating reform laws would be undermined, and that higher-risk people would once again face prohibitively high rates.

Supporters of the association plans have responded to some of the criticisms—for example, by including in the legislation a stipulation that only associations that had been in existence for several years could offer such a plan. The intent is to prevent low-risk employers from forming an association solely for the purpose of being able to separate themselves from the larger insurance rating pool.

Critics also worry that the federal regulations do not provide sufficient consumer protections related to reserve requirements and other practices that are normally subject to state insurance regulation.

It is worth pointing out that if association plans were to draw their membership primarily from people who already have insurance, they would have little effect on reducing the number of uninsured. They might be able to offer lower-priced coverage to their members, but if this were achieved by attracting only low-risk groups, it is not clear that a useful social purpose would be served.[37]

States could permit the establishment of association plans on their own without federal enabling legislation, but doing so would require states to exempt associations from mandated benefit requirements and other forms of insurance regulation. Even then, the lack of uniformity from state to state would make it more difficult for association plans to operate on the national level.

[37] Elliott K. Wicks and Jack A. "Meyer, *Small employer health insurance purchasing arrangements: can they expand coverage?* National Coalition on Health Care, May 1999.

Employer and Individual Mandates

Employer Mandate. A high proportion of non-elderly Americans get their health-insurance coverage through the workplace. More than 80 percent of people who lack health insurance are members of families in which at least one person is in the work force. Given these facts, many people have concluded that an effective way to extend insurance coverage would be to build on the employer-based system. One option would be to mandate that employers provide coverage to all employees and pay a substantial portion of the premium. A similar approach is the so-called "pay or play" option: employers could either provide coverage themselves or pay a fee, presumably to government, that would be used to finance coverage for their employees.

California has recently passed legislation that incorporates the pay or play model (joining Hawaii as the only other state that has an employer mandate). The California approach is to require employers with 20 or more workers to pay a fee to a government agency; the fee is waived for employers that provide coverage to their employees and pay the prescribed portion of the premium. For the largest firms, those with 200 or more employees, the provisions will go into affect beginning in 2006. The requirements would apply to employers with 50 or more workers in 2007, and for employers with 20 to 49 employees, the law would apply only if the state provides a tax credit equal to 20 percent of the net employer cost of the fee.

A major advantage of using this approach to coverage expansion is that it does not require large increases in government spending. The cost is off budget—borne by employers instead of government—and thus requires no tax increase. In addition, the approach is sometimes seen as helping to bring about greater equity between employers who already provide coverage and those who do not. Particularly in the case of employers whose employees get coverage through an employed spouse, the mandate can be seen as a way of requiring the non-offering employers to pay their fair share. Moreover, compared to coverage expansion approaches that depend upon establishing a separate program for the uninsured, this approach also avoids the problem of "crowd out," which occurs when people already covered through private sources switch to the new public program and thereby put more of the burden on government and less on the private sector.

The approach, like all others, has disadvantages. Apart from its substantive merits or demerits, some people find the employer mandate approach philosophically objectionable simply because it involves a degree of compulsion, requiring some employers to do what they would otherwise not choose to do. From a more substantive standpoint, requiring employers to cover the cost of coverage is equivalent to mandating a substantial wage increase, at least in the short run. Some critics contend that the result would be layoffs of workers and higher prices for the products that employers produce, which would make these products less competitive in national and international markets. Economists, however, generally agree that in the longer run employers will pass back the cost to employees in the form of lower wages or other reductions in compensation. The argument is that in deciding how much labor to hire—which involves

weighing costs against benefits—employers consider the *total* compensation costs of hiring another worker and compare that to the additional revenue that the worker would bring in. Thus when making hiring decisions, employers will pay less in money wages if they have to pay more in the form of fringe benefits. If this reasoning is correct, the long-range effect on a state's competitive position relative to other states is likely to be little affected by an employer mandate. One type of employer is likely to be affected—those who pay only the minimum wage; they cannot legally pass back the costs of health insurance to their employees by lowering money wages. Hence, firms paying minimum wage that did not previously offer coverage might lay off some workers.

Any form of employer mandate faces a major hurdle: the federal ERISA legislation that prohibits states from regulating employer benefits. States can regulate insurers and stipulate what benefits they can and cannot offer, but they cannot require employers to offer certain kinds of health-insurance coverage or even to require coverage at all. States are able to regulate the kind of insurance that fully insured employers provide because they can regulate the kind of insurance that insurers can sell. But the ERISA pre-emption prevents states from mandating that self-insured employers provide coverage. Some legal experts believe that carefully crafted legislation can, *in effect*, allow states to require even self-insured employers to provide coverage. Presumably, this explains why the California legislation requires all employers to pay a fee but allows them to forgo payment if they provide insurance coverage to their employees. It seems certain that this approach will be tested in the courts.

Individual Mandate. One approach to achieving universal coverage would be for government to mandate that everyone have health insurance of one form or another. This may be the only way to insure that one segment of the insured population is covered: nationally, about 30 percent of the people who are uninsured have annual incomes in excess of $50,000. It is reasonable to conclude that most of these could afford to buy coverage but choose not to do so for some reason. Yet when these people incur some kind of catastrophic medical expense, they are likely to receive "free" care from the safety net system, thereby passing on their costs to the rest of the population. Mandating that everyone have coverage would go far toward solving what some see as a "freeloader" problem.

On the other hand, imposing an individual mandate does nothing to make coverage more affordable for the large portion of uninsured people who do not have sufficient resources to afford to coverage without subsidies. Their only choices would be to comply with law at great financial sacrifice by going without other needed items in their budget or to simply disobey the law. From a practical standpoint, this means that an individual mandate, if applicable to the entire population, must be accompanied by some sort of subsidy program to make coverage affordable for low-income people. It might be more feasible to implement an individual mandate for higher-income people, for example, perhaps those with incomes above 400 percent of the poverty level.

One practical problem is how to enforce a mandate. It would be possible to determine who does or does not have health-insurance by requiring all taxpayers to show proof of coverage at the time they file their annual tax returns. Of course, this approach would not be helpful in detecting noncompliance among people who do not file tax returns, as is the case for a significant number of low-income people whose income is so low that they are not required to file. Another issue is what kind of penalties to impose on those who fail to obey the law. Some analysts have suggested that a penalty that might be effective without being unduly onerous would be to deny those who are out of compliance the right to take advantage of some tax benefit, such as the personal income tax exemption.

Perhaps the most compelling objection to the individual mandate is that it involves a degree of compulsion that many people find unacceptable. But the supporters of the idea point out that all states require everyone who drives an automobile to have auto insurance, and most people find this quite acceptable.

No state has in place legislation that requires everyone to have coverage.

Tax-Based Reforms

Tax credits are designed to lower the cost of coverage by allowing people to subtract from their tax liability the amount of the credit. Most proponents of this kind of subsidy argue that the credits must be both refundable and advanceble if they are to be effective in inducing people to buy coverage. They must be refundable because many people who lack coverage have such low incomes that the credit would exceed their tax liability, which in many cases may be zero. A refundable tax credit provides eligible recipients the full amount of the credit regardless of their tax liability. Advanceability refers to making the credit available before the eligible person's taxes are due. The argument is that many low-income people will not have the resources to pay the monthly premium if they have to wait until tax time to get the money they are due.

It is important to be realistic about the size of the tax credits that would be needed to induce substantial numbers of people who now lack coverage to enter the insurance market. Most people who have studied the problem conclude that credits must cover at least 50 percent of the cost to produce a large increase in insurance enrollment. For example, the tax credits included in the Trade Adjustment Act of 2002, described below, cover 65 percent of the cost of coverage.

Federal Tax Credit Proposals

Some argue that in the absence of large-scale health reform, incremental coverage expansion through tax credits – possibly combined with expansions of public insurance (e.g., Medicaid and SCHIP) – is the most likely policy option to be enacted by Congress. However, while there is currently a resurgence of Congressional tax credit proposals relating to the promotion of health care coverage, most seem to be reviving old ideas. At present, there are approximately 50 proposals in both the House and the Senate that propose some sort of tax credit that is intended to increase access to health insurance for certain groups or populations of people. A quick summary of a few of the new federal proposals is presented in Appendix D.

Trade Adjustment Act of 2002

In August of 2002, President Bush signed the Trade Adjustment Act (TAA) of 2002 that provides a refundable tax credit to a few people. Only about 180,000 displaced workers and their families are eligible. These are people who are either (a) certain workers laid-off because of trade liberalization or (b) certain early retirees with former employers that no longer pay promised pensions. The program is designed to help eligible individuals purchase health insurance from a number of difference sources – COBRA, the group health plan of the individual's spouse or individual coverage – if coverage was in place at least 30 days prior to delinkage from employment.

At a State's option, eligible individuals can also purchase through:

- State-based continuation coverage;
- Coverage through a high risk pool;
- Coverage through a state employee health insurance program;
- Coverage through a program comparable to the state employee health insurance program;
- Coverage arranged between a state and a group health plan, and issuer or health insurance coverage, an administrator, or an employer;
- Coverage through a private purchasing pool, or
- Coverage through a state operated health plan that does not receive federal financial participation.

The TAA tax credit does not require that a person be previously uninsured in order to quality for the tax credit; however, individuals without prior coverage would be subject to the same pre-existing conditions limitations as participants in the type of purchasing option the state selected. Although the number of people who are eligible for this particular program is very small, some see it as a prototype for other similarly structured tax credit proposals that might cover large numbers of uninsured people. According to Stan Dorn, senior policy analyst at the Economic and Social Research Institute:

> "Many in Washington view these TAA credits as a test of health insurance tax credits for the uninsured in general. . . Displaced workers who lost their jobs and health insurance because of free trade need this legislation to succeed, but the stakes go far beyond this relatively small group of uninsured."[38]

State Tax Proposals

A review of 20 HRSA state planning grants shows that few states have actually implemented state tax credits as a mechanism to increase health insurance coverage among residents. However, several states have proposed or have made state policy recommendations that include tax credits as part of their policy program:

- **California** recommended a coverage expansion through a combination of refundable tax credits or vouchers targeted to small employers with significant numbers of lower-income workers, to families that have to pay more than a designated percentage of their income for employer-sponsored insurance, or to workers not offered employer-sponsored insurance.

[38] *State of the States: Bridging the Health Coverage Gap,* Robert Wood Johnson Foundation State Coverage Initiatives Program, January 2003, p.30.

- **Kansas** has recommended maximizing the use of the current tax credit for small businesses (credit is available under an existing state statute to small employers newly providing insurance to their employees), simplifying the process for applying for and obtaining the credit, and revamping a tax credit to provide greater incentive to employers not currently offering coverage and to reward small businesses when low-income workers do enroll in the plan they offer.
- **Massachusetts** has recommended tax incentives for all individuals/families that lack access to employer-sponsored coverage
- **New Hampshire** will consider, among many, a policy option that would provide sufficiently large tax credits to assist individuals and families in buying health insurance, and to help those who are already insured to maintain coverage.
- **Virginia** proposed creation of a small-employer tax credit that would provide subsidies directly to employers to help them provide coverage to their workers through a refundable tax credit. Eligibility would be limited to firms that have not provided coverage for at least 12 months and to firms with an average payroll below the average for small firms in the state.
- **Washington** has proposed several direct safety net subsidies, including tax credits for nonprofit hospitals and for providers.

Several states have also recommended and advocated support for federal tax credits. At first glance, federal tax credits might not seem to have much to do with state health policy, but the federal tax subsidies would compliment state efforts to provide health insurance to state residents, especially in states like South Dakota where the state has no individual or corporate income tax and the median household income is nearly 20 percent lower than the nation as a whole.

Community-Based Programs

As a result of the lack of national or even state level solutions to covering the uninsured, some communities have developed local coverage initiatives. The most common models provide preventive services and primary health care, including pharmacy, through either coverage or access models. Most of these programs are only available to residents of a particular county.

Access models often provide assistance in securing available free or discounted health care services. Some access models organize contributed health care services from community physicians and other providers.

Coverage models fund local programs that entitle enrolled eligible individuals to a limited number of health care benefits. Some communities have also implemented programs that provide coverage through subsidized employer-based health care. These programs are described as three-share or one-third share programs.

Coverage Models

The programs designated as "coverage models" enroll individuals in a health care program and provide some level of funding of the health care services these individuals receive.

Three-Share Programs

Three share programs are county-based initiatives that subsidize premiums for workers in firms that are not able to provide coverage on their own. These plans currently exist in six counties in Michigan and Illinois and are under discussion in additional communities in Illinois, Ohio and Florida. Under a "three-share" approach, the cost of health care services is split between the employer, the employee, and the community.

Each community establishes its own parameters for program participation. Since these programs are designed for businesses that have not been able to provide coverage on their own, there are qualifications businesses must meet to be eligible to participate. For example, eligible businesses are firms that haven't offered health insurance for a specified period of time, the size of firm is generally limited (perhaps to 20 or fewer workers), and there is a limit on the median wage (such as $10 or $15 per hour or less). While these programs must be HIPAA compliant, there are also qualifications for eligible employees such as length of employment (or expected term of employment) and full or part-time status.

Each community has developed its own unique benefit plan (including copayment requirements) based on the unique values of that community. Licensed insurers underwrite several of these

programs but others are outside of state insurance requirements and use third party administrators or special subsidiaries of licensed HMOs to manage the program.[39]

There are several key design features that increase the affordability of these programs for employers and employees. The most obvious is the public subsidy of approximately one-third of the cost of services. Another is development of a "bare bones" coverage program that is less expensive than most commercial health insurance. To date these programs have been developed as first dollar coverage (i.e. no deductibles) but may have limits on catastrophic coverage or limit covered services to those available in the local community. In addition, the rates paid to participating providers are generally closer to Medicaid rates than to commercial insurance rates. Another key to affordability is development of criteria for business and employee participation in a manner that doesn't create significant adverse risk.

Development and implementation of these programs is very time-consuming. It is not true in this arena that "if you build it, they will come". A key development step is to insure that the program is affordable for and attractive to the target market. Another implementation key is allocation of significant resources to one-on-one marketing once the product is developed. Owners of small businesses are often skeptical of the actual costs they will incur. They are also concerned about the risk of unaffordable future cost increases and creating an expectation on the part of employees that health care benefits will continue. This is especially true in the current economic environment in which employer sponsorship of health care, and especially dependent coverage, is decreasing.

As an example, the developers of Access Health in Muskegon Michigan did significant surveys of the local business community and had discussions with potentially interested businesses as they developed their program in 1999. Access Health has also committed significant resources to "marketing" their program to small business in Muskegon County. While Access Health still has not reached its enrollment capacity of 3,000 members, this program experienced faster enrollment growth than others that have taken a more passive approach. For example, one local program that did not engage in any significant marketing and enrollment efforts had only 50 individuals enrolled at the end of six months. All of these programs, including Access Health, experience significant membership turnover as small businesses come and go, so that even retention of current membership levels requires active marketing.

Limited Ambulatory Coverage Models

Michigan has the largest number of counties providing limited ambulatory coverage for low income uninsured individuals. There are currently twelve programs covering fifteen Michigan

[39] Two of the oldest programs are underwritten by non-profit organizations that are not licensed insurers. This feature is possible because of unique state statutory provisions. For example, in Michigan, entities created by counties under Michigan's Municipal Health Facilities Corporations Act can assume risk for the provision of health care services without being licensed as insurers. Similarly rural health care systems in Arkansas can take risk for health care services without becoming insurers.

counties with more than 25,000 individuals enrolled in these limited ambulatory coverage programs. These communities enroll low-income individuals in local programs that guarantee access to a defined set of benefits. These programs do not charge any premiums, but there are nominal copayments. Generally coverage is available for individuals with incomes below 150 percent of poverty if they currently have no health coverage and are not eligible for Medicaid or other public programs.

The benefits of these coverage programs usually include primary and preventive physician or nurse services and a limited pharmacy formulary. In addition, specialty physician services are covered upon referral from the primary care provider, and routine laboratory services and radiology are generally covered. Hospital services, including outpatient hospital care are generally not covered. Copayments vary, but most communities do not charge any copayments for primary and preventive care, but might charge $5 or $10 for specialty care. Pharmacy copayments are generally between $5 and $10 per prescription (with lower copayments for generic products).

Funding Coverage Models

A key aspect of three-share plans and ambulatory coverage programs is either development of a new source of funds or the ability to re-organize existing funds. In Michigan, the state has allowed communities to use some of the State's Medicaid Disproportionate Share Hospital (DSH) capacity to match local funds with federal Medicaid funds.[40] This mechanism has been used for both the three-share plans and the ambulatory coverage models.

In Illinois, one county is funding initial development and implementation of a three-share program with a grant from the Small Business Administrative. Long-term revenues are still under development in partnership with state government.

Access Models

Several communities across the United States have adopted programs designed to increase access to uninsured or underinsured patients without providing actual insurance coverage. While these programs vary in scope and size, one common element is the creation of a local network to improve access and continuity of care for the uninsured. At the very least, these programs are often designed to provide primary and preventative care while managing the use of inpatient and emergency care. But programs can be broad-based or more targeted in their scope. Cambridge Health Alliance and the consortium of safety net providers in Detroit provide

[40] Local government sends local funds to the state as an intergovernmental transfer. These local funds are matched with federal funds as a special Medicaid DSH payment is made to a local hospital. The local hospital donates the special DSH payment to the local non-profit organization that is offering the three-share program or the limited ambulatory coverage program. In addition to funding the coverage programs, some of the non-profit organizations also fund other health care initiatives in the community that would otherwise have been funded with the local funds that were used to match the federal dollars.

examples of full service, integrated service delivery networks. Disease management programs similar to the ones developed in Broward County, Florida and in Denver provide examples of more targeted approaches. Benefits offered through these programs range from limited primary care benefits to a comprehensive benefit package.

There are several benefits to coverage programs that provide access, not insurance. These programs can meet the needs of local communities without being "entitlement" programs. This makes it easier for local communities to directly meet the needs and to rally and capitalize on the political will of the local communities. Such programs have also been used to increase coordination between local safety net providers and other community resources, thereby creating greater efficiencies in the health care delivery system. Increasing the coordination between local safety net providers, in most cases safety net hospitals, helps to improve the financial outlook for these hospitals that would most likely serve as the anchors of the community networks.

In Marion County, Indiana, the Indianapolis Medical Society and the Hudson Institute have teamed up to create "Project Health," a community access program modeled on Buncombe County, North Carolina's Project Access. When Project Health is launched sometime in 2004, it will increase the supply of pro-bono specialty care for the uninsured and thereby aid and enhance the existing primary care efforts of physicians, clinics and hospitals. In this way, Project Health seeks to improve the health status of the uninsured population within existing resources and reduce the financial burden of uncompensated care on hospitals and the community.

Strengthening the Safety Net

Federal Community Health Center Grants

With state budgets dwindling and pressure on providers growing due to increasing numbers of uninsured or underinsured individuals, states are looking to alternate sources of funding to enhance and strengthen the safety net delivery system. The Community Health Center (CHC) Program is a Federal grant program funded under Section 330 of the Public Health Service Act to provide for primary and preventive health services in medically underserved areas where economic, geographic or cultural barriers limit access to primary health care. Approximately 4.4 million of the 11.2 million users of CHCs in FY 2002 were uninsured (38.9%).

Since 2001, the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) has expanded this program as a result of President Bush's five-year plan to add or expand health centers in 1,200 communities by 2006 and to increase the number of patients served annually to more than 16 million -- up from 10 million in 2001. In fiscal year 2002, the first full year of the President's initiative, HHS funded 171 new health center sites and awarded 131 grants to existing centers to help them build capacity and expand services. This expansion effort has created a window of opportunity for providers looking to apply for FQHC look-alike and/or Section 330 grant funding through the HRSA Bureau of Primary Health Care. Non-traditional providers, such as systems and public health departments, are now starting to go after this designation because it overrides state funding crises.

Both Federally Qualified Health Centers (FQHCs) and Section 330 grantees receive cost-based reimbursement for Medicaid and Medicare. Both also must meet governance and service requirements. Examples of specific program requirements include:

- Must be located in an MUA/MUP federally designated area or serve residents from predominantly from an MUA/MUP;
- Organization has established collaborative and coordinated delivery system;
- Must directly provide primary health care, preventative health services, case management, health education;
- Must provide or arrange for x-ray, lab, pharmacy services to complete treatment, preventive dental, mental health and substance abuse, emergency services, transportation, access to specialty medical care, and
- Site must have referral arrangements in place for hospitalization and discharge planning.

Examples of specific governance requirements are listed below:

- An FQHC look-alike and Section 330 community health center cannot be owned, controlled or operated by another entity;
- The Board must retain the right to hire and fire the executive director of the health center;
- The Board must retain the right to approve the health center project budget;
- The Board must establish the health center policies;
- The Board must consist of 9 to 25 members;
- The Board must have 51 percent membership of users of the health center or network of health centers;
- No more than half of the non-user members may derive more than 10% of their income from the health care industry, and
- The Board must meet 12 times a year.

There are differences between the two. The FQHC Look Alike process is a technical process, whereby applications are accepted on a rolling basis. The approval process is 90 days or longer. The size of the program is not explicitly designated. Section 330 is a competitive process where applications are accepted two or three times a year. Grantees receive up to $650,000 in annual grants. There are specific requirements to apply for a Section 330 grant. The health center or applicant must develop a health care and business plan, have a minimum number of providers (five FTEs in urban sites, three FTEs in rural sites). Section 330 funding would also make health centers eligible for additional programs such as "340B" drug prices for pharmacy drug pricing.[41]

There are five Section 330 programs:

- Community Health Center (Section 330 (e));
- Migrant Health Centers (Section 330 (g));
- Health Care for the Homeless (Section 330 (h));
- Public Housing Primary Care (Section 330 (i)), and
- Healthy Schools, Healthy Communities (Section 330 (e)).

Community Access Program

While several Federal Grant programs are designed to increase access to health services for certain populations, few resources are provided to help health care providers coordinate these services. The Community Access Program (CAP) is a federal demonstration project that was

[41] The 340B program is a program that allows community health centers and FQHC look-alikes to purchase prescription drugs at deeply discounted prices in order to provide patients with timely access to pharmacy services. CHCs can provide pharmaceuticals through in-house pharmacies or through a contract with a external pharmacy to provide the drugs they have purchased.

initiated in FY 2000 and is intended to create integrated physical, mental health, and dental service programs for uninsured persons by building "integrated health care systems among local partner organizations, all of which are committed to expanding health services to uninsured individuals."

In order to integrate services, grantee communities have:

- Created networks to share uncompensated care among health providers, and
- Linked hospital and clinic services through data systems that share information about patient populations.

CAP grants are designed to increase access to health care by eliminating fragmented service delivery, improving efficiencies among safety net providers, and by encouraging greater private sector involvement. Many CAP models provide for integration of substance amuse and mental health treatment into the primary care model. A majority of CAP grants fund the development and implementation of disease and case management protocols. Currently, CAP grants support 158 communities in urban, rural and tribal areas including three CAP grant recipients in Indiana: Health and Hospital Corporation of Marion County, the Healthy Communities Initiative of St. Joseph County and The Central Indiana Health System Community Access Program operating in four rural Indiana counties located near Indianapolis (Clinton County, Northern Madison County, Howard County, and Randolph County). A description of each of these grant projects is included in Appendix E.

CAP appropriations in recent years are as follows:

- In FY 2000, Congress provided $25 million for the CAP program;
- In FY 2001, Congress provided $125 million;
- In FY 2002, Congress provided $105 million, of which $20 million went towards new CAP grantees, and
- In FY 2003, President Bush signed a bill that authorized the new Healthy Communities Access Program (HCAP) for FY 2002 through FY 2006. HCAP received an appropriation in the amount of $105 million.

Conclusion

INDIANA MEDICAID ELIGIBILITY OVERVIEW

Category	Non-financial Criteria	Typical Family Unit	Monthly Income Limit for Typical Family Unit	Resource Limit	Coverage Type
Low Income Families	Dependent Child in Home	1 Adult, 1 Child	$229 (23% of FPL)	$1,000	Full
Pregnant Women	Pregnant	1 Unborn Child, 1 Adult	$229 (23% of FPL)	$1,000	Full, Terminates 60 days after delivery
	Pregnant	1 Unborn Child, 2 Adults, 1 Child	$2,300	No limit	Limited to pregnancy related services; Terminates 60 days after delivery
Newborn Children	Newborn Child of a female Medicaid recipient	2 Adults, 2 Children	No limit	No Limit	Full, Continues until child reaches age 1
Under age 19	Child under age 19	2 Adults, 2 Children	$2300 (150% of FPL)[1]	No limit	Full
Aged[2]	Age 65 or older	Married couple, Individual	Couple $829, Individual $552 (Same as SSI standards)	Couple $2,250 Individual $1,500	Full
Blind	Blind	Married couple, Individual	Couple $829, Individual $552 (Same as SSI standards)	Couple $2,250 Individual $1,500	Full
Disabled	Substantial & will last at least 1 year	Married couple, Individual	Couple $829, Individual $552 (Same as SSI standards)	Couple $2,250 Individual $1,500	Full
Medicare Catastrophic Coverage Act of 1988 (MCCA)	One Spouse in nursing facility, One Spouse in community	Married Couple	$1,515 plus a % of shelter expenses not to exceed $2267 for spouse at home	$18,132 - $90,660	Full
Qualified Medicare Beneficiary (QMB)[3]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1010, Individual $749 (100% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare premiums, deductibles, co-insurance
Specified Low Income Medicare Beneficiary[3]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1212, Individual $898 (120% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part B premium
Qualified Individual - 1[3]	Eligible for Medicare Part A	Married Couple, Individual	Couple $1364, Individual $1011 (135% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part B premium
Qualified Disabled Worker	Lost Medicare Part A due to Earnings	Married Couple, Individual	Couple $2020, Individual $1497 (200% of FPL)	Couple $6,000 Individual $4,000	Payment of Medicare Part A premium
MEDWorks	Employees with Disabilities	Married Couple, Individual	$2620 (350% of FPL), Spousal Income Exempt	Couple $4,000 Individual $2,000	Full

[1]Effective July 1, 1998, children age 1-5, inclusive, with income between 133% and 150% of the poverty level and children age 6 - 8, inclusive, with income between 100% and 150% of the poverty level became eligible. This expansion was "Phase One" of Indiana's Children Health Insurance Program (CHIP). Effective January 1, 2000, "Phase Two" of CHIP expanded to include children between 150% and 200% of the poverty level.

[2]Income Levels Jan 2003-Dec 2003. All income standards (except those for Low-Income Families and Pregnant Women - full coverage) and the MCCA resource limits are increased annually.

[3]Income Levels April 2003 - March 2004. All income standards (except those for Low-Income Families and Pregnant Women - full coverage) are increased annually.

APPENDIX B

Approved HIFA Waivers				
Name	**Start Date**	**Coverage Expansion**	**Federal Financing of State-only Programs**	**Funding Sources**
Arizona HIFA Amend.	Phase 1: 11/1/01 Phase 2: 1/1/03	Phase 1: 27,000 childless adults up to 100% FPL; Phase 2: 21,250 parents of SCHIP and Medicaid children 100-200% FPL.		Unspent SCHIP and Medicaid.
California Parental Coverage Expansion	On hold	275,000 parents, caretakers and legal guardians of SCHIP and Medicaid kids up to 200% FPL.		Unspent SCHIP
Colorado Adult Prenatal Coverage Expansion	10/02 (Enrollment closed 5/03)	13,000 pregnant women 134-185% FPL.		Unspent SCHIP
Illinois KidsCare Parent Coverage	10/02	300,000 parents of KidCare eligibles up to 185% FPL (when fully implemented). The initial expansion is projected to include 29,000 people.	Refinances the IL Comprehensive Health Insurance Plan (high-risk pool), State Hemophilia Program, State Renal Program and the KidCare Rebate Program.	Unspent SCHIP and Medicaid
Maine Care for Childless Adults	10/1/02	11,500 childless adults up to 100% FPL.		Unspent DSH
New Jersey Standardized Parent Service Package		12,000 individuals below 133% FPL. Dually eligible for the Medicaid and SCHIP 1115 demonstration		SCHIP and savings realized through reduction in benefit package.
New Mexico State Coverage Initiative	On hold	Childless adults and parents of Medicaid and SCHIP children to 200% FPL.		Unspent SCHIP
The Oregon Health Plan 2 (OHP2)	2/03	60,000 individuals with incomes up to 185% FPL, some of whom are already covered in a FHIAP (a state-funded premium assistance program). OHP Plus: previous Medicaid eligibles and pregnant women and children up to 185% FPL. OHP Standard: Parents of SCHIP and Medicaid eligible children and childless adults to 185% FPL. FHIAP: Families and individuals to 185% FPL.	Waiver includes federal funding for the FHIAP (a state-funded premium assistance program).	Unspent SCHIP and Medicaid

APPENDIX C

Overview: Dirigo Health[42]

Access

- Dirigo Health is a new program that includes health promotion, disease management, quality initiatives and arracnges health coverage through private insurance carriers to individuals, small business (<50 employees) and the self-employed – enrollees benefit from lower and more stable rates provided by participation in a larger group
- Universal access to affordable and quality health care is achieved in 5 years
    - MaineCare is expanded to cover more low income citizens: to 125% FPL for individuals and 200% FPL for adults with MaineCare eligible children
    - Individuals, families, small business employees and the self-employed with incomes below 300% FPL are eligible for subsidies to help pay Dirigo Health Insurance costs on a sliding scale based on ability to pay – up to $27,000 in income for an individual and $55,000 for a family of 4
    - In Phase II, employees in large businesses may participate
- $500,000 is appropriated to restore MaineCare's Physician Incentive Program

Cost Containment

- Commission to Study Maine's Hospitals - examining hospital costs
- Biennial State Health Plan to assess need and available resources, set statewide goals for health care access and establish a budget for planning statewide expenditures
- One year voluntary caps on cost and operating margin of insurers, hospitals and providers to inform State Health Plan
- Capital Investment Fund is created to place capital expenditures on a budget – ensures wise and appropriate allocation of resources
    - One year CON moratorium (from May 5, 2003) to inform Capital Investment Fund planning
    - Expand CON to ambulatory surgery centers and doctors offices for investments in new technologies costing over $1.2 million and capital expenditures over $2.4 million indexed to the CPI Medical Index
- Regulates premium increases - requires small group health plans to submit rate filings to the Superintendent of Insurance for review and approval and strengthens oversight of the large group market

Quality Improvement

- Maine Quality Forum is established – a quality watchdog for Maine providing more public information about costs and quality of health care
    - MQF will collect and disseminate research, adopt quality and performance measurers, issue quality reports, promote evidence based medicine and best practices, encourage adoption of electronic technology, make recommendations to the State Health Plan

Financing

- Individuals and businesses who volunteer to join Dirigo Health will make payments to receive an array of benefits, including health coverage
- Captures additional federal funds through expanded Medicaid eligibility
- Capture realized savings from the reduction in bad debt and charity care through savings offset payments by health insurance carriers, third-party administrators, and employee benefit excess insurance carriers. Payments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed the savings
- Use the savings offset payments to fund subsidies for those with incomes above MaineCare eligibility and below 300% of the federal poverty level after the first year and to fund the Maine Quality Forum
- Use about $52 million one time monies to fund subsidies during the first year of Dirigo Health enrollment and about $1 million to launch the Maine Quality Forum, until savings offset payments begin

[42] www.maine.gov/governor/baldacci/healthpolicy/reform_proposals

APPENDIX D

Pending Congressional Tax Credit Proposals

A quick summary of a few of the new Congressional tax credit proposals is presented below. (These proposals were all introduced in the first session of the 108th Congress.)

S. 1018—Health Care Tax Credit Enhancement for Workers and Steel Security Act of 2003: Expands availability of the refundable tax credit for health insurance costs of eligible individuals.

S. 86—Small Employer Tax Assistance for Health Coverage Act of 2003: Amends the IRS code to provide a credit for the health insurance expenses of small businesses.

S. 53: Amends the IRS code to allow small business employers a credit against income tax for employee health insurance expenses paid or incurred by the employer.

S. 1570 and H.R. 583—Fair Care for the Uninsured Act of 2003: Allows individuals a refundable credit against income tax for the purchase of private health insurance.

S. 100—Access to Affordable Health Care Act: Expands access to affordable health care, strengthens the health care safety net and makes health care services more available in rural and underserved areas by:

- Providing a credit for employee health insurance expenses (small business tax credit);
- Providing a refundable credit for uninsured families and a refundable health insurance costs credit and advance payment of credit to issuers of qualified health insurance;
- Allowing a deduction of 100 percent of health insurance costs of self-employed individuals, and
- Providing a credit for taxpayers with long-term care needs.

S. 1030 and H.R. 2402—Health Coverage, Affordability, Responsibility and Equity Act of 2003 [HealthCARE Act of 2003]: Helps expand the number of individuals and families with health insurance coverage by providing a credit for health insurance costs for low-income individuals and advance payment of credits for eligible low-income individuals. Low-income is defined as family income at or below 200 percent of the poverty level. Credits would be refundable and advanceable to ensure that people who owe no taxes could use them and that people have the money up front to pay their health insurance premiums. Tax credit recipients could buy into available plans or purchase

coverage from state-based health insurance purchasing pools modeled on the Federal Employees Health Benefit Program (FEHBP). The working poor would also be eligible for a tax credit if their share of employer-sponsored coverage were more than 5 percent of their income. Small business would be able to buy into state purchasing pools under this plan. Finally, states would be given new money to expand Medicaid to individuals with incomes at or below 100 percent of the poverty level.

APPENDIX E

Health & Hospital Corporation of Marion County
The Community Access Program Grant

Program Overview:

To address concerns about how, when and where indigent patients were receiving health care, Health and Hospital Corporation launched an innovative program designed to provide high quality health care to the low-income and uninsured residents of Marion County. Health Advantage (initially dubbed Wishard Advantage) was officially established in 1997 when HHC contracted with the Indiana University Medical Group (IUMG) to provide primary care to Marion County's indigent patients. The program is modeled after Indiana Medicaid and its goals include improving the overall quality of health care in Marion County, effectively coordinating and managing patient care, strengthening doctor/patient relationships, decreasing inappropriate emergency department use and producing reliable data regarding the indigent population to guide future decision-making and policy development.

As the Health Advantage program expanded to include safety-net providers throughout Marion County, it became clear that more services were required in order to effectively meet the needs of the indigent population. HHC pulled the diverse network of Health Advantage providers together to assess needs and strategize next steps. The group drafted a joint proposal to secure federal funds in June 2000 and received funding in the amount of $899,788 in March 2001. Supplemental funds in the amount of $173,215 were received in August of 2002 and an additional year's worth of funding in the amount of $629,852 was received in September 2002. One more year of funding is anticipated.

The program goals and outcomes to date are noted below:

- To implement a Pharmacy Assistance Program to reduce pharmacy costs at the clinic level and increase the availability of free pharmaceuticals to indigent patients.
    - Implemented across network. Pharmacy Assistance Coordinators at Health Advantage providersites have provided more than $1,300,000 worth of free pharmaceuticals to patients through this program to date. In addition, Wishard Hospital has recovered more than $4,000,000 worth of pharmaceuticals via bulk replacement.
- To create a comprehensive Case Management Program to improve the health status of patients with very high utilization needs.
    - Case management of the highest-need diabetic Health Advantage patients is ongoing. As of 6/30/03, 53 individuals were enrolled into the comprehensive case management program, 97 home visits had been conducted by the program's nutritionist and the mental health coordinator had logged 75 contacts. Other program outputs include an algorithm for assessing diabetic patients for depression, a mental health manual for primary care clinics and a comprehensive screening tool designed to capture significant health related items.
- To implement a countywide sliding fee scale system to help achieve uniform co-payment processes across the Health Advantage Network.

  - Complete.
- To develop a countywide electronic application and eligibility determination system to streamline entitlement program (i.e. Health Advantage and Medicaid) application processes and increase patient enrollment into appropriate programs.
  - Roughly 28,000 applications have been processed through *Ind-e-App* by 100 trained system users since go-live on November 15, 2002. From those applications, roughly 25,000 people have been enrolled into Health Advantage (note that there may be several applicants on any given application). More than 20,000 referrals to other entitlement programs, based upon preliminary eligibility screens, have been generated by the system as well. Demonstrated qualitative outcomes of the system include improved customer service, increased application accuracy, increased financial counselor accountability, an expedited application and enrollment process for Health Advantage, prompt receipt of Medicaid reimbursements and access to reliable data regarding the indigent population of Marion County. Conversations with the State of Indiana regarding future Ind-e-App integration with their front-end eligibility system are ongoing.

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The Healthy Communities Access Project (HCAP)* is a community collaborative that focuses on creating an integrated system of health care for the uninsured and underinsured populations in St. Joseph County, Indiana. HCAP's overarching goal is to maximize access to health care services and to eliminate disparities of health outcomes through a "high touch, high tech" integrated program.

- HCAP has three components: case management for clients with asthma, diabetes, or hypertension; a volunteer physician network; and the expansion of a community health information network.

- HCAP works with the medically uninsured and underinsured who are at or below 150% of the federal poverty level.

- Collaborators in HCAP include Healthy Communities Initiative of St. Joseph County, Indiana Health Centers, Inc., Memorial Health and Hospital System, Inc., Saint Joseph Regional Medical Center, Inc., the United Way of St. Joseph County, the Council of Clinics, and the St. Joseph County Medical Society.

HCAP Component Goals

- Provide a comprehensive care management system through a network of local service providers coordinated by case management staff called Family Health Navigators (FHN's). With this focus on increased case management, the Family Health Navigator Program expects to reduce hospitalizations and emergency room visits for its target population by 10%. (We are currently providing intensive case management for 104 clients.)

- Improve access to physician services (primary care and specialty) by developing a systematic and equitable referral process for the uninsured. (We currently have 110 physicians enrolled in our network and hope to begin enrolling patients in October 2003.)

- Continue to further develop and expand the community health information network, a clinical management information system that allows for secure access to patient medical records from multiple sites. The goal is to have clinical data and patient encounters accessible in a timely fashion, thus eliminating the potential for fragmented health care and reducing duplication in health care services including office visits, laboratory tests, x-rays, and pharmaceuticals.

* HCAP is funded by a grant from the Health Resources & Services Administration (HRSA).

Central Indiana Health System Community Access Program

Program Overview

The Community Access Program (CAP) was created in FY 2000 by the Department of Health and Human Services, and funded through the Health Resources and Research Administration. The purpose of this program is "to assist communities and consortia of health care providers to develop the infrastructure necessary to fully develop or strengthen integrated systems of care that coordinate health services for the uninsured and underinsured."

The goal is to coordinate services to allow the uninsured and underinsured receive more efficient and higher quality of care as well as gain entry into the a comprehensive system of care. In order to achieve this goal, health care providers are expected to work with other, sometimes non-traditional partners, often competitors to achieve the desired outcomes for the target populations.

Expected Results

The funded CAP programs, through the integration and coordination of services, are expected to result in:

- A system of care that provides coordinated care to the target population.
- Increased access to primary care resulting in a reduction in hospital admissions for ambulatory sensitive conditions (diabetes, asthma, heart disease etc.) among the uninsured.
- Elimination of unnecessary, duplicate functions in service delivery and administrative functions, resulting in savings to reinvest into the system.
- Increased numbers of low-income uninsured people with access to a full range of health services.

The Central Indiana Health System Community Access Program addresses the health care needs of the uninsured and underinsured population in four rural Indiana counties located near Indianapolis. The area includes Clinton County, Northern Madison County, Howard County, and Randolph County. The uninsured rate in the target area in 1998 was about 12%. The population in the target sites is 171,191, with 54,961 (32%) living at less than 200% poverty. Approximately 41,380, or 75%, of these people are not being served by the current safety net providers.

CAP Coalition Members

St. Vincent Health
Indiana Health Centers, Inc.
Advantage Health Solutions, Inc.sm
Butler College of Pharmacy and Health Sciences
Health and Hospital Corporation of Marion County

Central Indiana Health System CAP Projects

- Assure a continuum of quality health and health-related services to the uninsured population at community-based primary care sites.
- Facilitate coordination of services through establishment of a management information system (MIS) to enable client tracking among safety net providers.
- Improve the ability of providers to address the cultural and linguistic issues presented by the fast-growing Hispanic population.
- Improve access to free or reduced-cost prescription drugs for the uninsured and the underinsured.
- Implementation of Project Access in 2 counties.

- Create a long-term strategy to sustain the goals of providing access care to the target populations.

Evidence of Progress

- Since March 02, visits to the emergency room for primary care services decreased by 9% overall (15% ↓ in one county and 13% baseline ↓to 3% current quarter in a second county).
- Since March 02, admissions for ambulatory sensitive conditions as a percent of total admissions decreased by 250 admissions overall.
- In the year 3/02-3/03, over 7900 individuals were assessed for access to related health care, social, legal and human services resulting in 1100 new referrals to primary care providers. These individuals were also assessed for 15 diseases and health risk factors.
- Since March 02, 1697 vulnerable individuals in the target sites have accessed free or reduced cost drugs with a market value over $337,000. These individuals would not have accessed these drugs if not for the CAP project.
- Trained Medical Interpreters: 8, enrolled for Spring 03 class: 19. St. Vincent Frankfort now has 24 hour interpreter coverage.
- Average percent of patients keeping their Primary Care appointments is 80%. The range is 75% - 99%.

Current Initiatives

- Culturally and linguistically appropriate cardiovascular disease management (CVDM) protocol directed at individuals with a third grade level of comprehension in both English and Spanish.
- Purchasing generic cardio vascular drugs for the above patients who do not qualify for the pharmaceutical assistance programs. This is the basis for the agreement with PharmaCare below.
- Piloting a cultural diversity program at one of four targeted hospitals. This program involves the creation of a diversity counsel made up of hospital staff, a self assessment conducted by the counsel, a diversity plan and implementation of the plan. This work is being conducted under the guidelines of the Office of Civil Rights (OCR) in compliance with the OCR Act of 1964 and the Office of Minority Health's recommendation for meeting the mandates outlined in the Cultural and Linguistically Appropriate Services in Health Care.

Financial Matching: Community Access Program and Pharmacare Collaboration

$104,000 of the CAP grant goes toward purchasing generic, cardiovascular drugs for patients enrolled in the Cardio Vascular Disease Management protocol. These drugs will be accessible for patients who **do not** qualify for drugs through the MDS system. PharmaCare will credit the program with an additional $52,000, a match of half of the grant money available for medication purchase. PharmaCare will contribute an additional $5,000 toward the program in 2003. The CAP Program will thereby have a credit at PharmaCare of $161,000 to be drawn down via providing patients with generic cardiovascular medications.